No. 02-469-CFX Title: The Black & Decker Disability Plan, Petitioner
v.
Kenneth L. Nord

Docketed: September 23, 2002 Court: United States Court of Appeals for the Ninth Circuit

See also:
01-1840

Entry	Date	Proceedings and Orders
	Sep 19 2002	Petition for writ of certiorari filed. (Response due October 23, 2002)
	Sep 19 2002	LODGING consisting of eleven bound copies of related material submitted by counsel for the petitioner.
	Nov 6 2002	DISTRIBUTED for Conference of November 27, 2002
	Nov 7 2002	Response requested.
	Nov 22 2002	Brief of respondent Kenneth L. Nord in opposition filed.
	Dec 11 2002	REDISTRIBUTED for Conference of January 10, 2003
	Jan 10 2003	Petition GRANTED. SET FOR ARGUMENT April 28, 2003. **********
	Feb 24 2003	Joint appendix filed.
	Feb 24 2003	Brief of petitioner Black & Decker Disability Plan filed.
	Feb 24 2003	Appendix of petitioner filed.
	Feb 24 2003	Brief amici curiae of Peabody Energy Corporation, et al. filed.
	Feb 24 2003	Brief amici curiae of National Association of Manufacturers, et al. filed.
	Feb 24 2003	Brief amici curiae of American Council of Life Insurers, et al. filed.
	Feb 24 2003	Brief amicus curiae of American Benefits Council filed.
	Feb 24 2003	Brief amici curiae of Central States, et al. filed.
	Feb 24 2003	Brief amicus curiae of Bert Bell/Pete Rozelle NFL Player Retirement Plan filed.
	Feb 24 2003	Brief amici curiae of Delta Family-Care Disabilty and Survivorship Plan, et al. filed.
	Feb 24 2003	Brief amicus curiae of United States filed.
	Feb 24 2003	Brief amicus curiae of Erisa Industry Committee filed.
	Mar 7 2003	CIRCULATED.
	Mar 12 2003	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Mar 28 2003	Brief of respondent Kenneth L. Nord filed.
	Mar 28 2003	Brief amicus curiae of AARP filed.
	Mar 28 2003	Brief amicus curiae of American Medical Association filed.
	Mar 28 2003	Brief amicus curiae of National Employment Lawyers Association filed.
	Mar 28 2003	Brief amicus curiae of National Organization of Social Security Claimants' Repr. filed.
	Apr 17 2003	Reply brief of petitioner Black & Decker Disabability Plan filed.
	Apr 18 2003	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided

No. 02-469-CFX

Entry	Date	Proceedings and Orders
		argument GRANTED.
	Apr 18 2003	Record filed.
	Apr 21 2003	Record filed.
	Apr 28 2003	ARGUED.

Supreme Court, U.S.
FILED

No. 02 469 SEP 19 2002

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In The
Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Ninth Circuit erred in holding that an ERISA disability plan administrator's determination of disability is subject to the "treating physician rule" and, therefore, the plan administrator is required to accept a treating physician's opinion of disability as controlling unless the plan administrator rebuts that opinion in writing based upon substantial evidence on the record.

LIST OF PARTIES

The parties to the proceeding below are the Petitioner-Defendant, The Black & Decker Disability Plan and the Respondent-Plaintiff, Kenneth L. Nord. There are no other parties.

RULE 29.6 STATEMENT

Petitioner is not a corporation, it is a funded benefit plan sponsored by Black & Decker (U.S.) Inc., which is a wholly owned subsidiary of The Black & Decker Corporation, which is a publicly held corporation.

RELATED CASES

The United States Court of Appeals for the Ninth Circuit decision in this case was based upon its previous decision in *Delta Family-Care Disability and Survivorship Plan v. Frank Regula*, No. 81-1840, which is before this Court on a Petition for a Writ of Certiorari.

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PETITION FOR WRIT OF CERTIORARI

Petitioner-Defendant, The Black & Decker Disability Plan, respectfully petitions for a writ of certiorari to review the July 15, 2002, decision of the United States Court of Appeals for the Ninth Circuit in the above-entitled proceeding finding that the plan administrator of an ERISA controlled disability plans must apply the "treating physician rule" when reviewing a request for disability benefits and that failure to use the "treating physician rule" is evidence of a conflict of interest.

OPINION BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit reversing the decision of the United States District Court for the Central District of California and the opinion of the United States District Court for the Central District of California are reproduced in the Appendix.

STATEMENT OF JURISDICTION

The judgment of the Circuit Court of Appeals was entered on July 15, 2002. This Petition for a Writ of Certiorari is filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. Section 1254(1).

STATUTES AND REGULATIONS INVOLVED

Relevant provisions of the United States Department of Labor, Employee Retirement Income Security Act of

1974, *Benefit Claims Procedure Regulation* Questions, are reproduced in the Appendix,

STATEMENT OF THE CASE

Respondent was a Material Planner for Kwikset Corporation, a subsidiary of The Black & Decker Corporation. [Appendix, Petitioner's Supplemental Excerpt of Record ("SER") 6] His responsibilities as a Material Planner included ordering goods, interacting with vendors and maintaining inventory levels. [SER 6] His job was sedentary. [SER 8-9] It involved up to six hours of sitting and up to two hours of standing or walking. [SER 154] Respondent's job did not require him to climb, twist, bend over, crouch, stoop, balance, reach above shoulder level, push or pull, grasp, or make repetitive motions with hands or feet. [SER 154] His job description provides that occasionally he was required to carry up to 20 pounds, but never more. *Id.*

As a Kwikset employee, Respondent participated in the company sponsored disability plan ("Plan"). [SER 7] On or about July 15, 1997, Respondent ceased working due to a back injury and submitted a claim for long term disability benefits under the Plan. [SER 7] The Plan provides long term benefits for participants who are disabled from doing their regular job for the Company for the first 30 months of disability, and continuing benefits thereafter for those participants who are disabled from any gainful occupation for which the employee is reasonably qualified. [SER 18, 31]

I. THE CLAIM AND APPEALS PROCESS AND THE PLAN'S DECISION-MAKING AUTHORITY

The Plan provides:

"The determination of Disability shall be made by the Plan Manager based on suitable medical evidence and a review of the Participant's employment history that the Plan Manager deems satisfactory in its sole and absolute discretion." [SER 31] The Plan also vests the Plan Manager with the authority to delegate one or more of his responsibilities to a Claims Administrator. [SER 38]

On February 16, 1998, MetLife informed Respondent that his claim was denied and that he could "request a review of [his] claim" by sending a request to MetLife's "Group Claims Review." [SER 8] On March 25, 1998, Respondent's counsel sent a letter to MetLife requesting review of the denial. [SER 8,159-160] Between March 25, 1998, and October 14, 1998, Respondent's counsel and MetLife exchanged letters and medical documentation. [SER 44-45, 158-160] On October 15, 1998, and October 21, 1998, MetLife made a recommendation to the Plan Manager to uphold the denial of Respondent's claim and provided the Plan Manager with all of the information upon which it relied in coming to that conclusion. [SER 8, 43, 53] The Plan Manager reviewed the information, conducted a further investigation and agreed with MetLife's recommendation. [SER 8-9] The Plan Manager informed Respondent of the results of the first step of his appeal by letter on October 27, 1998. [SER 9]

A. Respondent's Back Injury

Respondent's X-rays and MRI's revealed that he has degenerative disc disease, "mild bilateral L5 radiculopathy," but no spinal stenosis or disk herniation and no root compression. [SER 54-56] At Appellee's request, Respondent was examined by Dr. Antoine Mitri, an independent medical examiner. [Respondent's Excerpts from the Clerk's Record, Record 21:BD 0138]

Respondent informed Dr. Mitri that he had experienced chronic low back pain for 15 years. [SER 54] However, this claim was contradicted by his treating physician's records which, though dating back to 1993, first reported back pain only five months prior to his last day at work in 1997. [SER 54-57, 65-76] There is no evidence that Respondent was prescribed pain killers before July 1997. [SER 65-76] The medical records show that Respondent stated that "medication helps" his pain, he "feels worse without medication" but it is "tolerated with medication," and that his "symptoms are controlled with Relafen, occasional Darvocet and Flexeril." [SER 79, 98, 100]

Dr. Mitri's independent medical examination notes, dated July 17, 1998, provide that Respondent had "no limitation" with respect to transportation, standing, sitting, changing positions between standing and sitting, reaching forward and overhead, grasping or handling, finger dexterity, operating electrical equipment and concentrated visual attention. [SER 58] Dr. Mitri notes "some limitation in assuming cramped or unusual positions," twisting, pushing or pulling, repetitive movements, and operating a truck or dolly. *Id.*

Dr. Mitri's report concludes that Respondent suffered from degenerative disc disease and chronic myofascial pain syndrome. [SER 54-56] However, he also concluded that:

> [after] reviewing the patient's job description, and on the basis of the general examination and neurological examination, and after reviewing the report of his test, I think that the patient should be able to do sedentary work with some interruption by walking in between. Accordingly, I do not think the patient is disabled to perform that kind of work even though he is complaining from low back pain [because] all the work up that was done did not really show any evidence to substantiate disability in doing sedentary work with some walking interruption in between. *Id.*

MetLife sent Dr. Mitri's report to Respondent's attorney and asked that he submit the report to Respondent's treating physician and obtain his comment on it. [Respondent's Excerpts from the Clerk's Record 21:BD0134] Respondent never provided his physician's response to Dr. Mitri's opinion, despite a second request. [Respondent's Excerpts from the Clerk's Record 21:BD0131] Instead, Respondent's attorney contacted Janmarie Forward, a Human Resource representative at Kwikset, and requested that she complete a "Work Capacity Evaluation" responding to several of his questions. [SER 46-48] Among the questions he asked her were:

> Dr. Mitri indicates that's [sic] Kenneth Respondent can do sedentary capacity, as long as he can interrupt his sitting by walking in between at will. In your employer statement provided to Metropolitan, you have described the job as requiring sitting

between 5 and 6 hours in a day and standing and walking between 1 and 2 hours in a day. Assume that the need to stand and walk to relieve pain is unpredictable and that when the pain requires walking about, the individual must get up and move.

Could the individual with those limitations perform the work of a material planner?

___yes ___no

Ms. Forward responded "yes." [SER 47-48]

Respondent's counsel also asked the following question:

Dr. Mitri describes Kenneth Respondent as suffering from degenerative disc disease and a chronic myofascial pain syndrome. You have indicated in your employer statement provided to Metropolitan that the work of a material planner requires continuous interpersonal relationships and frequent exposure to stressful job situations. Assume that Kenneth Respondent would have a moderate pain that would interfere with his ability to perform intense interpersonal communications or to act appropriately under stress occasionally (up to one-third) during the day.

Could individual [sic] of those limitations perform the work of a material planner?

___yes ___no

Ms. Forward responded "no." *Id.*

After receiving MetLife's benefit file and MetLife's recommendation that the denial of Respondent's claim be upheld, Ray Brusca, the Plan Manager, telephoned Ms. Forward and investigated her response to the question

concerning whether Respondent could perform his job if his pain "interfere[d] with his ability to perform intense interpersonal communications or to act appropriately under stress." [SER 8-9] After questioning Ms. Forward about the specific responsibilities that Respondent performed and the reason she responded as she did, the Plan Manager agreed with MetLife's conclusion that Respondent was not disabled from performing his own job. [SER 9]

II. DISTRICT COURT DECISION

Respondent sought review of the Plan Manager's decision by filing a Complaint in the Central District of California under 29 U.S.C. Section 1132(a)(1)(B). At the conclusion of discovery, Petitioner and Respondent made cross motions for summary judgment. The District Court granted Petitioner's motion and denied Respondent's motion. The District Court reviewed the denial of benefits for an abuse of discretion under the standard set forth in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). [SER 202] In doing so, the District Court rejected Respondent's contention that *de novo* review was appropriate because the Plan Administrator filled the dual role of Plan Administrator and insurer. The District Court held that Respondent had failed to present sufficient evidence that this apparent conflict of interest affected the decision to deny Respondent benefits. [SER 203-4] *See, Tremain v. Bell Industries*, 196 F.3d 970, 976 (9th Cir. 1999) ("If, however, the program participant presents 'material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the

beneficiary,' a rebuttable presumption arises in favor of the participant") (internal citation omitted).

The District Court concluded that Respondent did not abuse its discretion in denying Respondent's claim for benefits. The District Court noted that "the mere fact that the plan administrator's decision is directly contrary to some evidence in the record does not show that the decision is clearly erroneous." [SER 204-5] The District Court rejected Respondent's arguments that the decision was "clearly erroneous" because: 1) it was contrary to the opinion provided by a Black & Decker employee that Respondent could not perform his job, if his pain *"interfere[d] with his ability to perform intense interpersonal communications or to act appropriately under stress"*; and 2) it credited the medical opinion of an independent medical examiner over those of Plaintiff's treating physicians. [SER 205-6] The District Court concluded that the company employee's opinion lacked sufficient foundation. [SER 206] It also concluded that the opinions of treating physicians were not entitled to more weight than any other medical opinion. [SER 207] After reviewing the entire administrative record, the District Court concluded that the Plan Manager did not abuse his discretion in denying Respondent's claim for benefits. [SER 208]

III. NINTH CIRCUIT DECISION

The Ninth Circuit Court of Appeals reversed the District Court's finding that the Black & Decker employee's "opinion" regarding Respondent's ability to perform his job lacked foundation, and held that the Plan's rejection of her opinion was evidence of a conflict of interest which affected the decision to deny benefits. The Ninth

Circuit also relied on its ruling in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F. 3d 1130 (9th Cir. 2001), which requires application of the "treating physician rule" to ERISA governed disability plans. Specifically, the Ninth Circuit held that Petitioner's rejection of the conclusions of Respondent's treating physicians without providing "specific, legitimate reasons" based on "substantial evidence in the record" was both evidence of a conflict of interest and a breach of its fiduciary duty to Respondent.

REASONS FOR GRANTING THE PETITION

This Petition should be granted because there are conflicting decisions between six Circuit Courts of Appeal and there is confusion in the district courts. In addition, this plan like many other ERISA controlled disability plans is national in scope and two circuit courts have issued conflicting decisions as to whether this plan administrator's decisions are subject to the "treating physician rule." The Ninth Circuit's decision forces this plan administrator to use conflicting standards of plan administration based upon the circuit court that has jurisdiction. This conflicts with the ERISA mandate for uniform plan administration. *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2169, 153 L. Ed. 2d 375 (2002).

One of the Congressional concerns in drafting ERISA was "not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans. . . . " *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). One of ERISA's

goals was to " ... establish a uniform administrative scheme. ... " *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). "Uniformity is impossible, however, if plans are subject to different legal obligations in different states." *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001).

ERISA and its Department of Labor ("DOL") regulations are written to provide a balance between plan flexibility and enrollee confidence in disability plans and efficiency in the disability insurance and labor markets. There are no provisions in ERISA which require a plan administrator to use the "treating physician rule." ERISA regulations are written " ... to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with prudent administration of the plan." (*Benefit Claims Procedure Regulation*, Question B-4; *www.dol.gov/pwba*) The DOL has the authority under ERISA to adopt regulations governing the administration of benefit claims for disability plans. While the DOL, as recently as 2001, issued numerous new and revised ERISA regulations, it has never required ERISA disability plan administrators to apply the "treating physician rule."

Most of the "treating physician rule" cases revolve around conflicting stereotypes of benefit plan administrators and physicians. Respondent and the Ninth Circuit Court of Appeals believe that employee plan administrators have an inherent tendency to cheat other employees. Conversely, they believe that treating physicians are inherently credible and that plan administrators should rely upon the physician's obligation to the patient to

insure the physician's credibility[1]. Other Courts of Appeal hold that the treating physician's opportunity to bill for more services creates an inherent conflict of interest and that the plan administrator's obligations as a co-employee and a fiduciary should be relied upon.[2] Most of the decisions ignore the most obvious reason not to trust the treating physician – "physician's bias." To provide proper medical care, a physician has to build trust with her patient. If the patient reports that he cannot work, the physician in an effort to maintain the physician-patient relationship may report that the patient is disabled from work, without considering whether the patient is actually malingering. As stated by the Seventh Circuit in *Stephens v. Heckler*, 766 F.2d 284, 289 (7th Cir. 1985):

> "The patient's regular physician may want to do a favor for a friend and client, and so the treating

---

[1] In *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001), the Ninth Circuit said that the treating physician: "is employed to cure and has a greater opportunity to know and observe the patient as an individual" (citations deleted); in *Edgerton v. CNA Ins., Inc.*, No. 01-2597, 2002 U.S. Dist. LEXIS 15490 at *22, (PA Aug. 6, 2002), the court stated that, "treating physicians are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations."

[2] *See, e.g., Sally v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992), "We have considerable doubt about holding the rule applicable in ERISA cases. Under it, the treating physician would stand to profit greatly if the court were to find benefits should not be terminated. There is a clear and strong conflict of interest, and we are doubtful that a court should defer automatically to his or her testimony."

> physician may too quickly find disability. The regular physician also may lack an appreciation of how one case compares with other related cases. A consulting physician may bring both impartiality and expertise." (citation omitted.)

All of these stereotypes are poor attempts to generalize a complex subject and should be ignored. Common sense says that some doctors will lie for their patients, others won't; some plan administrators will ignore their fiduciary obligations, others won't. However, no one has any actual or concrete evidence to show that most doctors tell the truth and most employee plan administrators cheat or vice versa. Therefore, a draconian rule that the treating physician's opinion must be given controlling weight belies common sense. Rather the resolution should be left to the entity charged with making the decision – in this case the plan administrator. As stated by the court in *Dray v. Railroad Retirement Bd.*, 10 F.3d 1306, 1311 (7th Cir. 1993), "In the case of dueling doctors, it remains the province of the hearing officer to decide whom to believe – a treating doctor whose experience and knowledge about the case may (or may not) be relevant to understanding the claimant's condition, or a consulting specialist who may bring expertise and knowledge about similar cases."

The Ninth Circuit's holding in *Regula* that there is "no reason why the "treating physician rule" should not be used under ERISA" begs the question. *Regula*, *supra*, 266 F.3d at 1139. The Court's decision is devoid of any legal basis, any factual basis or any public policy reason to infuse the "treating physician rule" into ERISA disability plans. The only policy reason that the decision offers is the limp reasoning that adoption of the rule will provide consistency for the Court to review disability determinations. *Id.*

In other words, courts in the Ninth Circuit will have a lighter workload if the "treating physician rule" is applied to both Social Security disability and ERISA disability determinations.

Employers do not have to provide employee disability plans. One purpose of ERISA was to encourage employers to adopt such plans. The "treating physician rule" takes away employer discretion and forces employers to pay disability benefits even when their plan administrators have an honest and good faith belief that the employee is malingering. Employers, who are convinced their disability plan is being abused by malingering employees, have no incentive to increase plan benefits. Employers without disability plans have no incentive to adopt a plan which they believe will support and encourage malingering. Forcing the "treating physician rule" onto ERISA plan administrators is counterproductive to the basic purposes of ERISA.

I. THIS PETITION SHOULD BE GRANTED TO RESOLVE CONFLICTING DECISIONS BETWEEN THE SECOND, THIRD, FOURTH, EIGHTH, NINTH, AND ELEVENTH CIRCUIT COURTS OF APPEALS

Currently only the Ninth Circuit Court of Appeals has unequivocally adopted the "treating physician rule" for ERISA disability cases. Four Circuit Courts, the Second, Fourth, Seventh and Eleventh, have unequivocally rejected the "treating physician rule" for ERISA cases. The Third Circuit Court has used the "treating physician rule" as an analogy to support a decision. One Circuit Court, the Fifth, has expressed doubt that the rule applies to ERISA

cases. The Eighth Circuit in an early decision appeared to have adopted the "treating physician rule," but in four subsequent cases has rejected the rule. Another Circuit Court, the Sixth, rejected the "treating physician rule," but did not publish the decision.[3] The First and Tenth Circuits have not ruled on the issue.

A. THE NINTH CIRCUIT CASES

In the Ninth Circuit case of *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), a plan administrator terminated the long term disability benefits of an employee. The employee relied upon the opinions of his treating physicians while the plan relied upon the opinions of expert examining physicians. The Ninth Circuit stated that "the treating physician rule can assist courts to enforce the accuracy of disability determinations under ERISA" and therefore found "no reason why the rule should not be adapted" to such cases. *Id.* at 1139. The Court ruling reflects an inherent trust in treating physicians and an inherent mistrust of examining physicians: "far more troubling is the conflict of interest inherent when benefit plans repeatedly hire particular physicians as experts ... these experts have a clear incentive to make a finding of 'not disabled' in order to save their employers money and to preserve their own consulting arrangements." *Id.* at 1143.

Since the decision in *Regula*, courts in the Ninth Circuit have followed the decision. *Nord v. Black & Decker*

[3] *Jackson v. Metropolitan Life*, 24 Fed. Appx. 290, 2001 U.S. App. LEXIS 23792 (6th Cir. 2001) (unpublished).

Disability Plan, 296 F.3d 823 (9th Cir. 2002); *Ehrensaft v. Dimension Works, Inc. Long Term Disability Plan*, No. 01-15062, 2002 U.S. App. LEXIS 7876 (9th Cir. 2002) (unpublished); *Olive v. Am. Express Long Term Disability Benefit Plan*, 183 F. Supp. 2d 1191 (C.D. Cal. 2002)

B. THE SECOND, THIRD, FOURTH, FIFTH, SEVENTH AND ELEVENTH CIRCUIT CASES

The Second Circuit, in *Conners v. Connecticut General Life Ins. Co.* 272 F.3d 127, 135 n. 4 (2nd Cir. 2001) expressly refused to adopt the "treating physician rule." In that case, the employee claimed that he was totally disabled. His treating physicians agreed. However, a reviewing physician found that he was able to perform some work. The court remanded the case to the district court with the following direction:

> "We do not adopt for these purposes – that is, when a district court reviews an ERISA administrator's decision under a de novo standard – the 'treating physician rule,' a standard developed in the Social Security context requiring 'that the fact-finder give greater deference to the expert judgment of a physician who has observed the patient's medical condition over a prolonged period of time."
>
> "As a rule designed to encourage the development of the administrative record so that the district court can determine whether the administrator's decision was supported by substantial evidence, the 'treating physician rule' serves no purpose in the context of de novo review."

Id. (citation omitted).

The Third Circuit in *Skretvedt v. E.I. Dupont De Nemours & Co.*, 268 F.3d 167 (3d Cir. 2001) recently used the "treating physician rule" as an analogy for its determination in an ERISA case. In that case, an employee applied for disability benefits. The court found that the employee's disability was supported by all of the treating and examining physicians who provided an opinion. The court then stated:

> "We find it relevant that Drs. Binhammer and Schiff had long-term treatment relationships with Skretvedt and that therefore they were uniquely able to provide detailed longitudinal information on Skretvedt's condition. We have long recognized that in the analogous area of disability benefits determinations under the Social Security Act, the 'opinions of a claimant's treating physicians are entitled to substantial and at times even controlling weight.' *Fargnoli v. Halter*, 247 F.3d 34, 43 (3d Cir. 2001); see also *Cotter v. Harris*, 642 F.2d 700, 704 (3d Cir. 1981); (7th Cir 1985) *Regula v. Delta Family-Care Disability Survivorship Plan*, No. 98-55853, 2001 U.S. App. LEXIS 20851, at *21 (9th Cir. Sept. 24, 2001) (applying the 'treating physician rule,' which requires administrative law judges to defer to a treating physician's opinions when adjudicating Social Security disability benefits, when reviewing an ERISA plan administrator's termination of benefits)." *Id.* at 184.

Since the Court found no conflict among any of the physicians' opinions, it is unclear whether this decision is an adoption by the Third Circuit of the "treating physician rule" or not. However, it is clear that district courts in the Third Circuit and the next Third Circuit panel will have to

decide whether this decision adopts the "treating physician rule" and therefore is binding on them.

The Fourth Circuit has rejected the "treating physician rule" in *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-08 (4th Cir. 1999).[4] In *Elliott* the Court reviewed a plan administrator's decision termination of benefits based upon statements of treating and examining physicians' opinions. The plaintiff urged the court to adopt the "treating physician rule" and to base its review on the entire opinion of her physician. The court declined to adopt the "treating physician rule." *See, also, Sheppard & Enoch Pratt Hospital, Inc. v. Travelers Insurance Co.*, 32 F.3d 120, 126 (4th Cir. 1994) (hospital attempting to recover disability plan benefits for a patient's expenses not entitled to invoke the "treating physician rule" "[t]o require the Plan to give conclusive weight to the opinion of the treating physician would deprive it of its role in determining medical necessity").

The Fifth Circuit has expressed doubt that the "treating physician rule" applies to ERISA cases, but has declined to rule. In *Sally v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) the court stated:

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[4] The same plan that is at issue in this case was recently reviewed by the Fourth Circuit in an unpublished opinion in *Webster v. Black & Decker (U.S.), Inc.*, No. 01-1946, 2002 U.S. App. LEXIS 6574 at **14 (4th Cir. 2002) (unpublished). In that case the court reviewed the plan administrator's determination that six treating physicians who found the plaintiff disabled were wrong. The court stated: "We have recognized that it is the Plan Administrator's responsibility to resolve conflicting medical assessments."

> "This Court has not addressed the propriety of the "treating physician rule" in ERISA cases. We have considerable doubt about holding the rule applicable in ERISA cases. Under it, the treating physician would stand to profit greatly if the court were to find benefits should not be terminated. There is a clear and strong conflict of interest, and we are doubtful that a court should defer automatically to his or her testimony." (citation omitted.)

In the Seventh Circuit case of *Wilczynski v. Kemper Nat'l Ins. Co.*, 178 F.3d 933, 938 (7th Cir. 1999), without referring to the "treating physician rule," the court declined to provide any special weight to the opinions of the treating physicians. In that case, an employee with multiple sclerosis was given disability benefits under the company ERISA disability benefit plan. On a review of her continuing disability, the plaintiff offered the opinion of a number of treating physicians and argued that the opinion of treating physicians should control. The plan relied upon the opinions of three examining physicians to terminate her disability benefits. The court held that there was adequate evidence on the record to support the plan administrator's decision.

In the Eleventh Circuit, in the case of *Turner v. Delta Family-Care Disability and Survivorship Plan,* 291 F.3d 1270, 1274 (11th Cir. 2002) the court held that the "treating physician rule" " . . . is contrary to the law of this Circuit" and the administrator could consider all medical reports. *See, also, Jett v. Blue Cross and Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989).

C. THE EIGHTH CIRCUIT DECISIONS

One Circuit Court of Appeal, the Eighth, has issued conflicting decisions in regard to applying the "treating physician rule" to ERISA plans.[5] In *Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996) the court overturned the plan administrator's decision to terminate disability benefits when it rejected the opinions of two treating physicians and one examining physician in favor of the opinion of a reviewing physician. The court stated: "We have held, in Social Security cases, that a reviewing physician's opinion is generally accorded less deference than that of a treating physician, and we apply this rule in disability cases under ERISA as well." *Id.* (citation omitted). However, the Circuit has rejected the "treating physician rule" in all subsequent cases. *Conley v. Pitney Bowes*, 176 F.3d 1044, 1049 (8th Cir. 1999) (The rule is not that a treating physician's opinion trumps all other evidence, but that a court must give it appropriate weight); *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 842 (8th Cir. 2001) (a treating physician's opinion does not automatically control, since the record must be evaluated as a whole); *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 n.3 (8th Cir. 2001) (a treating physician's opinion does "not automatically

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[5] The Eighth Circuit has a rule that "one panel cannot overrule another," that is, where a circuit court of appeal panel has issued a decision, subsequent circuit court panels are bound to that opinion until the case is overruled by an *en banc* decision or by a United States Supreme Court case. *See, e.g., U.S. v. Franklin* 250 F.3d 653, 665 (8th Cir. 2001). Whether that rule is intact or has been violated makes little difference to national plan administrators trying to sort out which standard to apply in the Eighth Circuit.

control, since the record must be evaluated as a whole"); *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793, 799 (8th Cir. 2001).

II. THE PETITION SHOULD BE GRANTED TO RESOLVE CONFUSION IN THE DISTRICT COURTS

A number of district courts have reviewed the "treating physician rule" in regard to ERISA plans and have looked to their circuits for usable guidance and found none available. *Durr v. Metropolitan Life Ins. Co.*, 15 F. Supp. 2d 205, 213 (D. Conn. 1998), *Lamoreaux v. Medtronic, Inc.*, No. 1:01-CV-179, 2001 U.S. Dist. LEXIS 13625 at *11-12 (W.D. Mich. 2001). A recent example is *Soltysiak v. Unum Provident Corp.*, No. 2:01-CV-15, 2002 U.S. Dist. LEXIS 238 at *12-14 (W.D. Mich. 2002) where the court stated:

> ". . . in Social Security disability determinations, greater weight is to be given to a treating physician's opinion than the opinions of other doctors. This rule was established because a treating physician is employed to cure not merely to evaluate, has typically been treating a patient over a long period of time, and has a greater opportunity to know the patient than an examining physician who sees the patient on one occasion and whose reports are less thorough. *Id.* The Sixth Circuit has not ruled, however, on the applicability of the 'treating physician rule' to ERISA cases. Other circuits are split. Compare *Regula v. Delta Family-Care Survivorship Plan,* 266 F.3d 1130, 1139 (9th Cir. 2001) (holding that the same rationale for the 'treating physician rule' in Social Security cases applies to ERISA cases as well), *Donaho v. FMC Corp.*, 74 F.3d 894, 901

(8th Cir. 1996) (applying the rule in disability case under ERISA) n.2, with *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994) (rejecting the treating physician rule when an ERISA plan administrator is making a determination about the medical necessity of treatment); *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (expressing "considerable doubt about holding the rule applicable in ERISA cases"); *Jett v. Blue Cross & Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989) (stating that the rule is not applicable to determinations under ERISA-governed plan where treating physician has an economic interest in benefits being paid). One court in this district declined to apply the rule to an ERISA case because the Sixth Circuit has not found that the rule is proper in the ERISA context and because of the potential conflict of interest a treating physician has in benefiting from the continuation of benefits."

The Court should grant this petition. Far too many courts have spent far too much time discussing whether the "treating physician rule" applies to ERISA plans or not. Too many national plan administrators have scratched their heads trying to resolve whether an individual claimant is in a "treating physician rule" jurisdiction or not. Too many court decisions have applied different standards to the same plan. *See, e.g., Turner v. Delta Family-Care Disability and Survivorship Plan,* 291 F.3d 1270, 1273-4 (11th Cir. 2002) ("treating physician rule" does not apply); *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 843 (8th Cir. 2001) ("treating physician rule" does not apply); and

Regula v. Delta Family-Care Survivorship Plan, 266 F.3d 1130, 1139 (9th Cir. 2001) ("treating physician rule" applies); *see, also, Webster v. Black & Decker (U.S.), Inc.*, No. 01-1946, 2002 U.S. App. LEXIS 6574, at **14 (4th Cir. 2002) (unpublished) ("treating physician rule" does not apply); and *Nord v. The Black & Decker Disability Plan,* 296 F. 3d 823 (9th Cir. 2002) ("treating physician rule" applies).

The issues are clear. Either plan administrators are to be trusted and given flexibility to do their jobs or not. Either treating physicians are to be given predominance in determining disability or they are not. Either employers are going to be encouraged to fund disability plans by allowing permissive administration or they are not. Either there are going to be uniform national standards for review of ERISA plan claims, as stated in *Rush Prudential HMO, Inc. v. Moran,* 122 S. Ct. 2151, 2169, 153 L. Ed. 2d 375 (2002), or there will continue to be inconsistent standards applied throughout the United States. Granting this Petition will bring resolution to an issue which has plagued and, unless resolved, will plague the Circuit and District Courts for years.

CONCLUSION

Petitioner respectfully requests that this Court grant the Petition, on this important issue, to resolve the conflicts within individual circuits and between the circuits.

Respectfully submitted,

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FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

KENNETH L. NORD, *Plaintiff-Appellant*, v. THE BLACK & DECKER DISABILITY PLAN, *Defendant-Appellee*.	No. 00-55689 D.C. No. CV-99-00408-CM OPINION

Appeal from the United States District Court
for the Central District of California
Carlos R. Moreno, District Judge, Presiding

Argued and Submitted
October 16, 2001 – Pasadena, California

Filed July 15, 2002

Before: Betty Binns Fletcher, Dorothy W. Nelson, and M. Margaret McKeown, Circuit Judges.

Opinion by Judge B. Fletcher

COUNSEL

Lawrence D. Rohlfing, Esq., Santa Fe Springs, California, for the plaintiff-appellant.

Lee T. Paterson, Esq., Los Angeles, California, for the defendant-appellee.

OPINION

B. FLETCHER, Circuit Judge:

This case arises under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*. Plaintiff Kenneth Nord seeks disability welfare benefits from defendant Black & Decker Disability Benefits Plan ("Black & Decker" or the "Plan"). The district court granted summary judgment in favor of Black & Decker, holding that it did not abuse its discretion by denying Nord disability benefits under the terms of the Plan. Nord appeals. We have jurisdiction pursuant to 28 U.S.C. § 1291. Based on our recent decision in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), we conclude that the district court erred in reviewing the disability determination for an abuse of discretion. We review *de novo* and reverse.

FACTUAL AND PROCEDURAL BACKGROUND

Kenneth Nord was formerly employed as a Material Planner for Kwikset Corporation, a subsidiary of the Black & Decker Corporation. Nord's responsibilities as a Material Planner included ordering goods, interacting with vendors, and maintaining inventory levels. The position is a sedentary one, requiring up to six hours of sitting and up to two hours of standing or walking per day.

Through his employment at Kwikset, Nord was enrolled in the Black & Decker Disability Plan. The language of the Plan grants absolute discretion to the Plan

Manager to make disability determinations.[1] The Plan also invests the Plan Manager with the authority to delegate one or more of his responsibilities to a Claims Administrator. The third-party Claims Administrator retained while Nord's claim was under review was Metropolitan Life Insurance Company ("MetLife"). The Plan provides long-term benefits coverage for participating employees who are prevented by disability from occupying their regular jobs for the first 30 months of the disability. At issue here is Nord's disability from performing his regular job for 30 months. Continuing benefits are available for those participants who are prohibited from engaging in any gainful employment for which they are qualified due to their disabilities.[2]

In March 1997, Nord consulted Dr. Hartman regarding his experience with intermittent hip and low back pain. Dr. Hartman concluded that Nord suffered from mild degenerative disc disease at the L4-L5 and L5-S1 vertebral

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[1] The Plan provides that:

> The determination of disability shall be made by the Plan Manager based on suitable medical evidence and a review of the Participant's employment history that the Plan Manager deems satisfactory in its sole and absolute discretion.

[2] The Plan defines "disability" to mean:

> the complete inability (whether physical and/or mental) of a Participant to engage in his regular occupation with the Employer (during the first 30 months of Disability), and became with the thirty-first month of Disability, the Participants [sic] complete inability (whether physical and/or mental) of a participant to engage in any gainful occupation or employment with any employer for which the Employee is, as of his Disability Date, reasonably qualified by education, training or experience.

levels.[3] In July 1997, Dr. Hartman diagnosed Nord as suffering from sciatica and disc disease at L4-L5 and placed him on medication. After a one-week trial with that treatment plan, Dr. Hartman concluded that Nord had experienced no improvement, and he took Nord out of work temporarily. He recommended orthopedic consultation while continuing medication. On July 16, 1997, Nord submitted a claim under the Plan for up to 30 months of long-term disability benefits.

On August 13, 1997, Dr. Hartman drafted a letter indicating that Nord was under his medical care and would be unable to return to work until he experienced sufficient recovery from his lumbar disc syndrome. Dr. Hartman wrote an additional letter in March 1998, after Nord had begun treatment by an orthopedist, Dr. Lytton Williams, confirming continuing medical treatment and restating his earlier conclusion that Nord remained unable to return to work. In April 1998, Dr. Hartman performed a physical capacity evaluation in which he estimated that Nord could sit for up to one hour a day and could occasionally lift up to five pounds.[4] Nearly identical findings were made by Nord's treating orthopedic physician, Dr. Williams, around the same time.

[3] This diagnosis was later reconfirmed by an MRI scan, conducted on July 23, 1997, which showed degenerative disc disease at L4-L5 and L5-S1, with disc desiccation and a mild diffuse bulge.

[4] At the same time, Nord underwent overlapping treatment from two orthopedic doctors, Dr. Silva and Dr. Mumtaz Ali. Both doctors confirmed aspects of Dr. Hartman's diagnosis, including the presence of lumbosacral pain requiring continued treatment with medication and physical therapy.

On February 16, 1998, MetLife informed Nord that his claim had been denied because he did not meet the "own occupation" definition of disability for the first 30 months of coverage. In the same letter, MetLife also informed Nord that he could "request a review of [his] claim" by sending his request to MetLife's "Group Claims Review." Nord requested review of his claim through a letter sent by counsel. Between March 25, 1998 and October 14, 1998, Nord and MetLife exchanged letters and medical documentation in an effort to process the review of his claim.

This review process included the Plan's referral of Nord to Dr. Antoine Mitri for independent evaluation of his medical claims. Dr. Mitri observed Nord to be normal except for some limitations in bending and assuming cramped or unusual positions. Dr. Mitri opined that Nord should be able to perform sedentary work, with no material limitations in his ability to sit, while taking pain reduction medication. However, the review process also included Nord's providing the Plan with a work capacity evaluation performed by Ms. Janmarie Forward, a human resources representative at Black & Decker, who determined that Nord lacked the capacity to perform the requirements of his job because of his physical limitations. Forward based this determination on the assumption that Nord faced chronic myofascial pain and that this experience of pain would make it impossible for him to carry on the necessary interpersonal relationships to perform his job.

MetLife made a final recommendation to the Plan Manager to deny Nord's claim, and the Plan Manager accepted that recommendation. In a letter dated October 27, 1998, the Plan Manager informed Nord by letter of the

outcome of this initial step in his appeal and explained how Nord could perfect his appeal under ERISA. Black & Decker indicated that it had rejected the opinion of Forward that Nord's pain syndrome prevented him from resuming work in his former position.

Nord filed this action in the district court on January 14, 1999, asserting that Black & Decker's denial of his disability benefits violated ERISA. On February 28, 2000, the parties filed cross-motions for summary judgment. The district court granted the defendant's motion and denied Nord's motion. The court found that Black & Decker did not abuse its discretion by denying Nord's disability claim. Nord appeals the district court's order.

STANDARD OF REVIEW

We review the district court's order granting summary judgment *de novo*. *See Robi v. Reed,* 173 F.3d 736, 739 (9th Cir. 1999). In addition, we review *de novo* "the district court's choice and application of the standard of review applicable to decisions of plan administrators in the ERISA context." *Regula v. Delta Family-Care Disability Survivorship Plan,* 266 F.3d 1130, 1138 (9th Cir. 2001); *see also Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.,* 125 F.3d 794, 797 (9th Cir. 1997).

In reviewing a grant of summary judgment, we "must determine whether the evidence, viewed in a light most favorable to the nonmoving party, presents any genuine issues of material fact and whether the district court correctly applied the law." *Warren v. City of Carlsbad,* 58 F.3d 439, 441 (9th Cir. 1995); Fed. R. Civ. P. 56(c). *See also Pomerantz v. County of Los Angeles,* 674 F.2d 1288, 1290 (9th Cir. 1982) (holding that the same standard applies for

review of denial of summary judgment). An issue is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248 (1986).

DISCUSSION

District Court's standard of review for Black & Decker's disability determination

The district court reviewed Black & Decker's termination of Nord's disability benefits under an abuse of discretion standard, despite Nord's allegations that Black & Decker was operating under a conflict of interest. Nord relies on the opinion of Black & Decker's own human resources representative and the opinions of three treating physicians that Nord was no longer capable of occupying his former position. He argues that Black & Decker's arbitrary rejection of these opinions constitutes material, probative evidence that it was operating under an actual conflict. Nord further argues that, because Black & Decker was operating under a conflict of interest, the district court should have reviewed the administrator's decision *de novo*.

The standard of judicial review for a disability determination by an insurer covered under ERISA varies depending on the plan language. We review *de novo* the decision of a plan administrator to deny benefits "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989); *see also Tremain v. Bell Indus., Inc.,* 196 F.3d 970, 976 (9th Cir. 1999). The plan language must be explicit. *See Kearney v.*

Standard Ins. Co., 175 F.3d 1084, 1090 (9th Cir. 1999) (en banc) (holding that plan language stating that the insurer will pay benefits "upon receipt of satisfactory written proof" of disability was ambiguous, and thus did not confer discretion). When the plan language confers discretion, we review the decision of the plan administrator under an abuse of discretion standard. *Tremain*, 196 F.3d at 976.

In this case, the plan language clearly confers discretion upon the Plan Manager both to determine benefits eligibility and to interpret the terms of the Plan.[5] However, the fact that the terms of the Plan confer broad discretionary authority upon the plan administrator does not end our inquiry into the proper standard of review. An insurer with a "dual role as the administrator and funding source for the [p]lan" has an inherent conflict of interest. *Lang*, 125 F.3d at 797. In *Firestone Tire & Rubber Co.*, the Supreme Court stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion." 489 U.S. at 115 (internal quotation marks omitted). We have held that our review in such cases is "still for abuse of discretion, [but it] is less deferential." *Tremain*, 196 F.3d at 976 (internal quotation marks omitted).

Black & Decker admits that it acts as both the funding source and the plan administrator with regard to the Plan. It notes that administration of the Plan in Nord's

[5] *See supra* note 1.

case had been delegated to MetLife, a third-party administrator. However, MetLife acted as the agent of Black & Decker and not as the independent executor of a true trust.[6] *See Lang*, 125 F.3d at 798 (stating that "plans such as this one, funded by insurers and also administered by them, are not true trusts"). Therefore, Black & Decker, through MetLife, was operating under an inherent conflict of interest.

The "less deferential" standard of review for cases involving conflicts consists of two steps:

> First, we must determine whether the affected beneficiary has provided material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary. If not, we apply our traditional abuse of discretion review. On the other hand, if the beneficiary *has* made the required showing, the principles of trust law require us to act very skeptically in deferring to the discretion of an administrator who appears to have committed a breach of fiduciary duty.

Atwood v. Newmont Gold Co., Inc., 45 F.3d 1317, 1323 (9th Cir. 1995). By providing material, probative evidence of a conflict, Nord would create a rebuttable presumption that the Plan's decision violated its fiduciary responsibilities. The Plan would then "bear[ ] the burden of rebutting the

[6] MetLife processes the insured's claim and makes a recommendation whether to grant or deny benefits; Black & Decker's Plan Manager makes the final disability determination after receiving MetLife's recommendation.

presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits." *Lang,* 125 F.3d at 798. If the plan fails to carry its burden, then we review *de novo* its decision to deny benefits. *Tremain,* 196 F.3d at 976.

This appeal is controlled by our recent ruling in *Regula v. Delta Family-Care Disability Survivorship Plan.* In *Regula,* we rejected the district court's application of the abuse of discretion standard to a claim for wrongful termination of disability benefits because the district court had failed to evaluate whether the insurer's apparent conflict of interest had affected its determination. If so, we would require that the court review the plan administrator's decision *de novo. Regula,* 266 F.3d at 1145-46; *see also Lang,* 125 F.3d at 799-800 ("The district court did not conduct the appropriate conflict of interest analysis and hence accorded [the insurer] a deference to which it was not entitled."). Our prior decisions have established that material, probative evidence of a conflict may consist of inconsistencies in the plan administrator's reasons, *Lang,* 125 F.3d at 799, insufficiency of those reasons, *Tremain,* 196 F.3d at 977, or procedural irregularities in the processing of the beneficiaries claims, *Friedrich v. Intel Corp.,* 181 F.3d 1105, 1110 (9th Cir. 1999). In *Regula,* we held that rejection of the opinions of the beneficiary's treating physicians could likewise establish conflict where the rejection is not "sufficiently supported by the record." 266 F.3d at 1147. On remand, we directed the district court to consider Delta's departure from the prevailing opinions of Regula's treating physicians as material, probative evidence of an actual conflict of interest but to allow Delta to rebut that evidence in a manner consistent with our prior

precedent. *See Lang,* 125 F.3d at 798; *see also Tremain,* 196 F.3d at 978.

In *Regula,* the conflict of interest issue was not litigated in the district court but was entertained by us on appeal because of its relevance to determining the standard of review. 266 F.3d at 1145-46. Therefore, we did not rule on the existence of a conflict of interest in that case. *Id.* at 1147. Rather, we remanded to the district court so that the defendant insurer would have an opportunity to rebut the material, probative evidence of conflict that we ascertained in our review of the district court record. *Id.*

In the case before us, the district court rejected Nord's argument that inconsistencies and procedural irregularities in Black & Decker's administration of his claim demonstrated the insurer's conflict of interest. In particular, the district court held that Black & Decker's rejection of the conclusion of its own human resources representative, Forward, was not material, probative evidence of a conflict. Forward opined that Nord was unable, due to his medical condition, to perform the functions of a Material Planner. Forward's opinion was solicited by the administrator; she relied on Dr. Mitri's assessment as provided by the administrator. To contradict her opinion out of hand is not only high-handed but also certainly some evidence of a conflict.[7]

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[7] In addition, Nord claims that the Plan violated its administrative procedural requirements by failing to provide, in its letter of October 27, 1998, specific reasons for rejecting the opinion of Forward. However, Black & Decker's letter was sufficiently responsive in that it provided the insurer's reasons for its ultimate decision to deny benefits. Black & Decker was under no duty to rebut with specificity all evidence adduced

(Continued on following page)

The district court erred also in its refusal to view Black & Decker's rejection of the prevailing opinions of Nord's treating physicians as germane to a determination of whether the Plan's administration was impaired by a conflict of interest. As discussed above, Nord was diagnosed with degenerative disc disease, sciatica, and myofascial pain syndrome. This diagnosis was confirmed by an MRI and CT scan and was not contradicted by Dr. Mitri, the independent clinician retained by Black & Decker to evaluate Nord's claim. Nord's primary treating physician, Dr. Hartman, concluded after a physical capacity evaluation that Nord could sit for up to one hour a day and could carry up to five pounds.[8] Black & Decker's own description of the physical requirements for a Material Planner indicate that the person occupying the position would have to sit for up to six hours a day and carry up to 20 pounds.[9] In addition, Dr. Hartman wrote two letters to Black & Decker in which he stated that Nord's medical condition prevented him from returning to work even though Nord had made improvements with physical therapy and

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by Nord to support his claim. *Vizcaino v. Microsoft Corp.*, 120 F.3d 1006, 1016 (9th Cir. 1997) (en banc) (Fletcher, B., J., concurring in part and dissenting in part) (stating that under ERISA the reasons for a denial of benefits "must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial") (quoting *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997)).

[8] This diagnosis of Nord's physical abilities was confirmed by an additional examination by Dr. Williams, who opined that Nord could sit for one hour at a time and for one hour during a day, and that he could occasionally lift up to five pounds.

[9] Nord represents that while working in his former position he was sometimes required to lift up to 60 pounds.

medication. Dr. Hartman's diagnosis, as well as his prescribed course of treatment, were confirmed by Nord's other treating physicians, Drs. Williams and Silva.

Dr. Mitri disagreed with Nord's treating physicians in two principal respects: First, Dr. Mitri found that Nord suffered from only minor limitations to his range of motion and in his ability to sit for long periods of time if he took his pain medication. The medications to which Dr. Mitri referred in drawing this conclusion (Relafen, Davrocet, and Flexeril) are all medications that were prescribed by Drs. Hartman and Silva for Nord at various stages throughout their treatment of his condition. Second, Dr. Mitri concluded that Nord could lift and carry up to 15 pounds less than 20% of the business day. Thus, Dr. Mitri concluded that, under medication, Nord could perform "sedentary work with some walking interruption in between."

Thus, the long-term treating physicians and Black & Decker's independent (but one-time) clinical examiner disagreed. The same clinical materials were available to both. In such a circumstance, under the treating physician rule, the plan administrator can reject the conclusions of the treating physicians only if the administrator "gives 'specific, legitimate reasons for doing so that are based on substantial evidence in the record.'" *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999) (quoting *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995)).

Nowhere in the record is any reason advanced as to why the treating physicians' opinions were unreliable and Dr. Mitri's more reliable. No evidence has been advanced that Nord's treating physicians considered inappropriate

factors in making their diagnosis or that Nord's physicians lacked the requisite expertise to draw their medical conclusions. Instead, the administrator appears merely to have preferred to rely upon the more favorable conclusions of its own examiner. Given its dual role as funding source and administrator for the Plan, we conclude Black & Decker breached its fiduciary duty to Nord as a beneficiary of the Plan due to a conflict of interest.

Because the issue of an apparent conflict of interest was litigated below, Black & Decker received ample opportunity to demonstrate that its termination of Nord's benefits was free from conflict by advancing sound reasons for its denial of benefits. It has provided none. Rather, it has simply asserted at every turn, and again before this Court, that it was under no duty to consider evidence that was unfavorable to its determination, whether coming from Nord's physicians or from its own human resources representative. We faced an analogous situation in *Tremain,* where we ruled that the district court had erred by failing to consider evidence even though it was outside of the administrative record in determining whether a conflict of interest had impaired the insurer's benefits determination. 196 F.3d at 976-77. Based on the evidence before us, presented to the district court before it granted the insurer's motion for summary judgment, we concluded that the insurer's inconsistent reasons for denying the beneficiary's claim constituted material, probative evidence of a conflict (a conclusion not reached by the district court) and that the insurer had failed to present any evidence to rebut the presumption that a conflict of interest had impaired its determination. *Id.* at 977.

Therefore, following our precedent in *Tremain* and *Regula,* we conclude that the disability determination

must be reviewed *de novo.* Under *de novo* review, the question becomes whether there is a genuine issue of material fact as to whether Nord is disabled. *See Newcomb v. Standard Ins. Co.,* 187 F.3d 1004, 1006 (9th Cir. 1999). After cross-motions for summary judgment, we find that, although further record development for *de novo* review is sometimes appropriate, *see Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan,* 46 F.3d 938, 943-44 (9th Cir. 1995), it is unnecessary in this case. Indeed, Black & Decker asserted in the district court that no additional evidence was necessary for an adequate *de novo* review. *See* Defendant's Memorandum of Points and Authorities in Opposition to Plaintiff's Motion for Summary Judgment at 17 & n.6. The administrative record reveals no genuine dispute as to whether Nord is disabled within the meaning of the plan for the first 30 months of coverage.

The only evidence advanced by Black & Decker to dispute the evidence of Nord's disability is Dr. Mitri's opinion that Nord is capable of performing sedentary work. A scintilla of evidence or evidence that is not significantly probative does not present a genuine issue of material fact. *Addisu v. Fred Meyer, Inc.,* 198 F.3d 1130, 1134 (9th Cir. 2000). We conclude that the lone opinion of Dr. Mitri, the doctor hired by Black & Decker, could not reasonably overcome all the other evidence demonstrating that Nord is disabled. Dr. Mitri's opinion is overwhelmed by substantial evidence in the record, including the opinions of three treating physicians that Nord's condition rendered him unable to meet the physical requirements of his position as a Material Planner. Viewing the administrative record as a whole, we conclude that no reasonable

trier of fact could conclude that Nord is not disabled. Therefore, we grant Nord's motion for summary judgment.

CONCLUSION

For the foregoing reasons, we reverse the ruling of the district court holding that Black & Decker was not operating under a conflict of interest. Upon a *de novo* review of the administrative record, we find that there is no triable issue of fact regarding Nord's disability and hold that Nord is entitled to disability benefits for the first 30 months of his disability.

REVERSED.

JUDGMENT

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NO. 00-55689
CT/AG#: CV-99-00408-CM
CT/AG#: CV-99-00408-CM

KENNETH L. NORD

Plaintiff-Appellant

v.

THE BLACK & DECKER DISABILITY PLAN

Defendant-Appellee

APPEAL FROM the United States District Court for the Central District of California, Los Angeles.

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Central District of California, Los Angeles and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the judgment of the said District Court in this cause be, and hereby is reversed.

Filed and entered: July 15, 2002

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

KENNETH L. NORD,
Plaintiff,
v.
THE BLACK & DECKER DISABILITY PLAN,
Defendant.

Case No. CV 99-0408 CM

ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

(Filed Mar. 22, 2000)

On February 28, 2000, Plaintiff's Motion for Summary Judgment and Defendant's Motion for Summary Judgment came before the Court on regular hearing. Having read and considered the moving papers, oppositions, and replies; the entire record in this action; and all other admissible evidence and argument offered in relation to the Motions, the Court hereby *grants* Defendant's Motion for Summary Judgment and hereby *denies* Plaintiff's Motion for Summary Judgment for the following reasons.

I.

Summary of Relevant Facts

This ERISA action arises from Plaintiff's claim for long-term disability benefits from Defendant. Plaintiff is a former employee of Kwikset Corporation ("Kwikset"), a subsidiary of Black & Decker Corporation. As a Kwikset employee, Plaintiff was entitled to participate in the Black & Decker Disability Plan (the "Plan"). Under the terms of the Plan, "disability" was defined as follows:

> the complete inability (whether physical and/or mental) of a Participant to engage in his regular occupation with the Employer (during the first 30 months of Disability and beginning with the thirty-first month of Disability, the Participants [sic] complete inability (whether physical and/or mental) of a participant to engage in any gainful occupation or employment with an employer for which the Employee is, as of his Disability Date, reasonably qualified by education, experience or training. Declaration of Raymond J. Brusca In Support of Defendant's Motion, Exh. B at 24.

On or about July 15, 1997, Plaintiff ceased working in his position as a Material Planner for Kwikset and submitted his claim for long-term disability benefits. A review of Plaintiff's administrative claim file reveals the following facts relevant to the disposition of the instant Motions:

– On or about March 10, 1997, Plaintiff consulted with Leo Hartman, M.D. because of the presence of intermittent pain in the lower back and hips for the preceding three or four weeks;

– Between March 1997 and August 1997, Plaintiff was regularly treated by Dr. Hartman for lower back pain, sciatica, leg pain, and degenerative disc disease. As part of his treatment by Dr. Hartman, pain killers were prescribed for Plaintiff;

– On or about August 13, 1997, Dr. Hartman recommended that Plaintiff seek an orthopedic consultation from Ismael Silva, M.D.;

– Also on or about August 13, 1997, Dr. Hartman wrote a letter in which he indicated that Plaintiff was

under his medical care and could not return to work until Plaintiff's lumbar disc syndrome had sufficiently recovered;

– As result of Plaintiff's consultation with Dr. Silva, Dr. Silva diagnosed Plaintiff with lumbosacral pain and prescribed physical therapy;

– On or about the same time as Dr. Silva's prescription of physical therapy for Plaintiff, Dr. Hartman also prescribed physical therapy for Plaintiff;

– Dr. Silva's treatment of Plaintiff included prescription painkillers as well as ordering an EMG and nerve conduction studies of Plaintiff's lower extremities in order to rule out disc disease;

– The results of the EMG and nerve conduction studies ordered by Dr. Silva suggested mild bilateral L5 radiculopathy;

– On or about January 12, 1998, Kwikset provided a statement regarding Plaintiff's claim for long-term disability benefits to Metropolitan Life Insurance Company ("MetLife"), the Plan's Third Party Claims Administrator. In that statement, Kwikset described Plaintiff's position as a Material Planner as requiring between five and six hours of sitting per day, one and two hours of standing, one and two hours of walking, the need to use the head and neck in the same position between one and two hours per day, looking up between one and two hours per day, and looking down between one and two hours a day. Kwikset further represented that the Material Planner position required occasional lifting and carrying of objects weighing up to 20 pounds, continuous interpersonal relationships, frequent exposure to stressful situations,

exposure to moving equipment and machinery, and overtime on a routine basis;

– On or about January 17, 1998, Plaintiff provided a response to a Personal Profile Evaluation as part of Metlife's assessment of his claim for long-term disability benefits. In the Personal Profile Evaluation, Plaintiff reported that he could not sit for more than 10 to 15 minutes at a time without pain, that he could not stand or walk for more than 10 to 15 minutes without pain, that pain radiated down his left leg and at times also down his right leg, that he walked until he experienced pain and then sat in a recliner and stood at invervals during a typical day, that he had no difficulty caring for his personal needs, that he did housework and that he got assistance from his mother with housework, that his father provided him assistance with shopping, that it takes him longer to mow his lawn because of his pain, and that his recreational activities included fishing and hunting although he had not been hunting since November of 1996. Plaintiff further stated that he expected to return to his job as a Material Planner if and when he could sit without pain; that, in the meantime, he did not expect to return to any other type of work on a full-time or part-time basis; and that he had no other sources of income;

– On or about January 23, 1998, Plaintiff returned to Dr. Silva for evaluation. Dr. Silva noted continued complaints of back pain, bilateral lumbosacral radiculopathy, and the continued use of prescription medication to control pain. Dr. Silva also found decreased lumboscaral range of motion and the presence of paralumbar muscle spasm;

– On or about February 16, 1998, MetLife wrote a letter to Plaintiff regarding his claim. In the letter, MetLife

disallowed Plaintiff's claim for benefits. In so doing, MetLife cited Plaintiff's responses in his Personal Profile Evaluation as well as Plaintiff's medical history since the onset of his lower back pain. MetLife's letter also notified Plaintiff of his right to seek review of its denial of Plaintiff's claim by the Plan's Group Claims Review;

– On or about March 4, 1998, Plaintiff returned to Dr. Hartman with continuing complaints of lower back pain. Dr. Hartman noted the presence of recurring low back pain consistent with a herniated disc. Dr. Hartman recommended continuing the present treatment regiment and seeking an orthopedic follow-up from Lytton Williams, M.D.;

– On or about March 23, 1998, Dr. Hartman wrote a letter concerning Plaintiff. In the letter, Dr. Hartman confirmed Plaintiff's continuing treatment for lumbar disc syndrome. Dr. Hartman also stated that Plaintiff would not be able to work until his condition was sufficiently controlled and that Plaintiff would likely be of work until December 31, 1998;

– On or about March 25, 1998, Plaintiff, through his counsel, formally requested review of the denial of his claim;

– On or about March 26, 1998, Plaintiff underwent a lumbar discogram and a CT scan of the lumbar spine both based upon a clinical history of degenerative disc disease. The discogram revealed a concordant pain pattern at L4-5 and L5-S1. The CT scan revealed annular thinning of the intervertebral discs and loss of disc space at L4-5 and L5-S1;

– On or about April 2, 1998, Dr. Williams completed a Physical Capacity Evaluation Plaintiff. Dr. Williams opined that Plaintiff could sit for one hour at a time and for one hour total during a day; that Plaintiff could occasionally lift or carry up to five pounds; that Plaintiff could not use his feet for repetitive movements; that Plaintiff could only occasionally bend, squat, crawl, climb, or reach; and that Plaintiff should be limited to mild exposure to temperature and humidity changes;

– On or about April 9, 1998, Dr. Hartman completed a Physical Capacity Evaluation of Plaintiff. Dr. Hartman opined that Plaintiff could sit for one hour at a time and for a total of one hour per day; that Plaintiff could occasionally lift up to five pounds; that Plaintiff could not use his feet for pushing or pulling of light controls; that Plaintiff could occasionally bend, squat, crawl, climb, or reach; and that Plaintiff should be limited to mild exposure to temperature and humidity changes;

– On or about June 22, 1998, MetLife advised Plaintiff that it had scheduled an independent medical examination of Plaintiff as part of its administration of Plaintiff's claim;

– On or about July 17, 1998, Antoine Mitri, M.D. conducted an independent neurological examination of Plaintiff pursuant to MetLife's request. Dr. Mitri concluded that Plaintiff suffered from degenerative disc disease and chronic myofascial pain syndrome. Dr. Mitri further concluded that there was no evidence of lumbosacral nerve root compression. Consequently, Dr. Mitri opined that Plaintiff should be able to do sedentary work with intermittent walking as necessary;

– On or about July 17, 1998, Dr. Mitri completed a Certified Consultant's Evaluation Summary Form as part

of MetLife's administration of Plaintiff's claim. In that form Dr. Mitri noted the presence of lumbosacral degenerative disc disease and chronic myofascial pain syndrome and that Plaintiff had suffered from low back pain for 15 years. Dr. Mitri opined that Plaintiff would have some limitations with respect to stairs and ladders and that Plaintiff would need to completely avoid scaffolding and heights. Dr. Mitri further found limitations with respect to cramped or unusual positions, pushing, pulling, or twisting of arm and leg controls, repetitive movements of hands or feet, and operating vehicles. Dr. Mitri completely forbade climbing, balancing, bending, stooping, squatting, and the operation of heavy equipment. Dr. Mitri opined that Plaintiff could perform sedentary work with occasional walking;

– At some point prior to October 20, 1998, Janmarie Forward, a Black & Decker human resources employee, completed a Work Capacity Evaluation sent to her by Plaintiff's counsel;

– On or about October 27, 1998, Black & Decker upheld MetLife's denial of Plaintiff's claim. Black & Decker based its decision on its conclusion that Plaintiff could return to work in his own occupation which was, in turn, based on the evidence in Plaintiff's administrative claim file;

– Subsequent to its decision to uphold the denial of Plaintiff's claim, Black & Decker requested a review of the medical records and correspondence relating to Plaintiff's claim by James Ebeling, M.D. Dr. Ebeling concluded that Plaintiff should be able to do sedentary work and he agreed with MetLife's decision to deny Plaintiff's claim.

II.

Applicable Standard

Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). In a trilogy of 1986 cases, the Supreme Court clarified the applicable standards for summary judgment. *See Celotex Corporation v. Catrett*, 477 U.S. 317 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986); *Matsushita Electrical Industry Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986).

The moving party bears the initial burden of demonstrating the absence of a genuine issue of material fact. *Anderson*, 477 U.S. at 256. Whether a fact is material is determined by looking to the governing substantive law; if the fact may affect the outcome, it is material. *Id.* at 248. If the moving party seeks summary adjudication with respect to a claim or defense upon which it bears the burden of proof at trial, its burden must be satisfied by affirmative, admissible evidence. By contrast, when the non-moving party bears the burden of proving the claim or defense, the moving party can meet its burden by pointing out the absence of evidence submitted by the non-moving party. The moving party need not disprove the other party's case. *See Celotex*, 477 U.S. at 325.

If the moving party meets its initial burden, the "adverse party may not rest upon the mere allegations or denials of the adverse party's pleadings, but the adverse party's response, by affidavits or as otherwise provided in

this rule, must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e).

In assessing whether the non-moving party has raised a genuine issue, its evidence is to be believed, and all justifiable inferences are to be drawn in its favor. *Anderson*, 477 U.S. at 255 (citing *Adickes v. S. H. Kress and Company*, 398 U.S. 144 (1970)). Nonetheless, "the mere existence of a scintilla of evidence" is insufficient to create a genuine issue of material fact. *Id.* at 252. As the Supreme Court explained in *Matshushita*,

> When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show that there is some metaphysical doubt as to the material facts. . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no "genuine issue for trial."

Id., 475 U.S. at 586-87.

To be admissible for purposes of summary judgment, declarations or affidavits must be based on personal knowledge, must set forth "such facts as would be admissible in evidence," and must show that the declarant or affiant is competent to testify concerning the facts at issue. Fed. R. Civ. P. 56(e). Declarations on information and belief are insufficient to establish a factual dispute for purposes of summary judgment. *Taylor v. List*, 880 F.2d 1040, 1045 (9th Cir. 1989).

Summary judgment is not treated as "a disfavored procedural shortcut" but as "an integral part of the Federal Rules as a whole, which are designed 'to secure the just, speedy and inexpensive determination of every action.'" *Celotex*, 477 U.S. at 327 (quoting Fed. R. Civ. P. 1).

III.

Analysis and Discussion

Exhaustion of Administrative Remedies

As a general rule, "[an ERISA] claimant must avail himself or herself of a plan's own internal review procedures before bringing suit in federal court." *Diaz v. United Agricultural Employee Welfare Benefit Plan and Trust*, 50 F.3d 1478, 1483 (9th Cir. 1995) (citing *Amato v. Bernard*, 618 F.2d 559, 566-68 (9th Cir. 1980)), *see also Pengilly v. Guardian Life Insurance Co. of America*, 81 F.Supp.2d 1010, 1022 (N.D.Cal. 2000) (setting forth the specific terms of a disability policy's appeal's procedures in order to analyze the issue of exhaustion of administrative remedies). "Although not explicitly set out in the statute, the exhaustion doctrine is consistent with ERISA's background, structure and legislative history and serves several important policy considerations, including the reduction of frivolous litigation, the promotion of consistent treatment of claims, the provisions of a nonadversarial method of claims settlement and a proper reliance on administrative expertise." *Diaz*, 50 F.3d at 1483. "Furthermore, prior fully considered actions by . . . trustees interpreting their plans and perhaps also further refining and defining the problem in given cases, may well assist the courts when they are called upon to resolve the controversies." *Pengilly*, 81 F.Supp.2d at 1022 (citing *Amato v. Bernard*, 618 F.2d at 568).

The Summary Plan Description ("SPD"), *see* Brusca Decl. Exh. A, clearly provides that a claimant may appeal to the Plan Administrator within 60 days of the initial denial of a claim and that the Plan Administrator will render its decision on the appeal within another 60 days.

Furthermore, the Plan Document itself, *see* Brusca Decl., Exh. B, provides that initial determinations of claims applications will be made by the Plan Manager or by a third party Claims Administrator who is providing administrative services to the Plan. *See* Brusca Decl., Exh. A, §9.07(A). Under the terms of the Plan Document, a claimant may appeal an initial denial of benefits to the Plan Manager within 60 days of the initial denial. *See id.* at §9.07(B). Finally, the Plan Document provides that the appeal will be decided by an Appeals Committee within 60 days of the date the claimant makes the appeal. *See id.* at §9.07(C).

Plaintiff argues that he exhausted his administrative remedies under the Plan Document and the SPD when he received a letter dated October 27, 1998 from Black and Decker, *see* Brusca Decl., Exh. D, notwithstanding the fact that this letter purported to inform Plaintiff of his right under ERISA to have claim reviewed on appeal yet again. Specifically, Plaintiff claims that the October 27, 1998 letter was notification of a final, binding decision on his appeal of MetLife's initial denial of his claim in its position as Third Party Administrator.

Defendant, however, characterizes MetLife's initial denial as a kind of recommendation to the Plan Manager which the Plan Manager upheld after further investigation. *See* Brusca Decl. ¶¶11-19. Therefore, according to Defendant, under the terms of the Plan and the SPD, Plaintiff was still entitled to an appeal to the Plan's Appeals Committee. *See id.* ¶¶20-22. Because, according to Defendant's position, Plaintiff did not pursue an appeal to the Plan's Appeals Committee, this action is barred for failure to exhaust administrative remedies. *See* Defendant's Motion at 3-6, Defendant's Opposition at 4-5.

The Court holds that Plaintiff has exhausted his administrative remedies by making his initial claim and seeking review by the Plan Manager which resulted in the denial in the October 27, 1998 letter. There is no ambiguity in the SPD about the internal appeals process and to the extent there is any ambiguity in the Plan Document itself, *see* Brusca Decl. Exh. B at §§9.07(A)-(B), Plaintiff should not be prejudiced thereby. The SPD clearly provides that Plaintiff is entitled to one level of internal appeal after the initial denial; the Plan Document has similar terms. Nothing in these documents puts a claimant on notice of the fact that an initial denial by the Third Party Claims Administrator might be a mere recommendation that must be ratified by the Plan Manager before an actual internal appeal can take place. Furthermore, the initial denial letter sent to Plaintiff by MetLife, *see* Brusca Decl. Exh. C at 147, also states that Plaintiff had 60 days to request a review of MetLife's initial denial. This language may have reasonably led Plaintiff and his counsel to conclude that the October 27, 1998 denial was the product of the only level of internal appeal to which Plaintiff was entitled under the SPD and the Plan Document. Consequently, the Court concludes that Plaintiff exhausted his administrative remedies and that, therefore, this action is not barred.[1]

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[1] Tellingly, the draft version of Black & Decker's October 28, 1998 denial letter which was written by MetLife stated that the decision to uphold MetLife's denial "is the final decision on review and constitutes completion of the full and fair review required by Mr. Nord's Plan and federal law." The draft denial letter further states "Please be advised that under the provisions of his Plan, no further administrative appeals are available to him concerning his disability benefit." Rohlfing Decl.,

(Continued on following page)

Appropriate Standard of Review / Conflict of Interest

An ERISA plan administrator's decision to deny benefits is subject to de novo review unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Tremain v. Bell Industries*, 196 F.3d 970, 976 (9th Cir. 1999) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). When such discretion is conferred, the exercise of that discretion is subject to review for abuse of discretion. *Tremain*, 196 F.3d at 976 (citing other Ninth Circuit caselaw).

"If, however, the plan administrator is also the insurer, that conflict of interest must be weighed as a factor in determining whether there is an abuse of discretion." *Id.* (citing *Snow v. Standard Insurance Co.*, 87 F.3d 327, 330 (9th Cir 1996)). In such a circumstance, a "less deferential" abuse of discretion standard is employed. *Tremain*, 196 F.3d at 976 (citing *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology*, Inc. 125 F.3d 794, 798 (9th Cir. 1997)).

"If, however, the program participant presents material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breech of the administrator's fiduciary obligations to the beneficiary, a rebuttable presumption arises in favor of the participant." *Tremain*, 196 F.3d at

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Exh. 2 at Bates No. BD 0039. Although the final version tracks MetLife's draft in many respects, the final version does not contain the above-quoted language. See Brusca Decl., Exh. D at 159 (Bates No. BD 0042).

976 (citing *Lang*, 125 F.3d at 798). "The plan then bears the burden of rebutting the presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits. *Tremain*, 196 F.3d at 976 (citing *Lang*). If the plan fails to carry this burden of rebutting the presumption, the fiduciary or administrator's decision to deny benefits is reviewed de novo. *Tremain*, 196 F.3d at 976 (citing *Lang*). Sufficient evidence of an actual conflict of interest includes, *inter alia*: (1) inconsistent position on the part of the administrator/fiduciary or (2) an administrator/fiduciary's failure to follow its own internal procedures or ERISA's mandatory claims procedures. *See Ellis v. Egghead Software Short-Term and Long-Term Disability Plans*, 64 F.Supp.2d 980, 985 (E.D.Wash. 1999) (citing *Lang*, 125 F.3d at 799, and *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1109-12 (9th Cir. 1999)).

Plaintiff concedes that the Plan Document grants discretion to the Plan Administrator. *See* Plaintiff's Motion at 4. Defendant likewise concedes that there is an apparent or technical conflict of interest due to Black & Decker's dual role as insurer and administrator. *See* Defendant's Motion at 11. However, Plaintiff has not sufficiently met his burden to invoke de novo review. *See* Defendant's Opposition at 10-15. More specifically, under *Ellis*, Plaintiff has not demonstrated that Defendant assumed inconsistent positions during the pendency of the internal claims assessment and internal appeal. Furthermore, to the extent that Defendant may have deviated from the SPD's and Plan Document's stated procedures for an internal appeal, this issue has been resolved in Plaintiff's favor above as it relates to exhaustion of administrative remedies and Plaintiff also has not shown that this

deviation caused a breach of fiduciary duty owed to him. *See Tremain*, 196 F.3d at 976 (plaintiff must produce sufficient evidence to show that the conflict of interest caused a breach of a fiduciary duty owed to him), *cf. Dames*, 49 F.Supp.2d at 1201 (a plaintiff is not entitled to a substantive remedy for violation of ERISA's reporting and disclosure requirements unless she can show reliance or prejudice).

Consequently, the Court holds that notwithstanding Defendant's apparent or technical conflict of interest, Defendant's decision to deny Plaintiff's claim for disability benefits is subject to review for abuse of discretion.

Propriety of Defendant's Denial of Plaintiff's Claim for Benefits

"It is an abuse of discretion for an ERISA plan administrator to make a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Atwood v. Newmont Gold*, 45 F.3d 1317, 1323-24 (9th Cir. 1995). "The mere fact that the plan administrator's decision is directly contrary to some evidence in the record does not show that the decision is clearly erroneous." *Snow v. Standard Insurance Co.*, 87 F.3d 327, 331 (9th Cir. 1996). "Rather, 'review under the clearly erroneous standard is significantly deferential, requiring a 'definite and firm conviction that a mistake has been committed.'" *Id.* (citing *Concrete Pipe & Prods., Inc. v. Construction Laborers Pension Trust*, 508 U.S. 602, 623 (1993)). "That standard certainly does not permit the overturning of a decision where there is substantial evidence to support the decision, that is, where there is 'relevant evidence [that] reasonable minds might accept as adequate to support a

conclusion even if it is possible to draw two inconsistent conclusions from the evidence.'" *Snow*, 87 F.3d at 331-32 (citing *Maynard v. City of San Jose*, 37 F.3d 1396, 1404 (9th Cir. 1994)). Finally, several courts have held that crediting the opinions of an independent medical examiner over the opinions of a claimant's treating physicians is not clearly erroneous or an abuse of discretion. *See, e.g., Voight v. Metropolitan Life Insurance Co.*, 28 F.Supp.2d 569, 578-81 (C.D.Cal. 1998) (Morrow, J.) (citing other cases), *Jordan v. Northrop Gruman Corp. Welfare Benefit Plan*, 63 F.Supp.2d 1145, 1161-64 (C.D. Cal. 1999) (Collins, J.) (citing other cases) (finding that the administrator's decision to deny benefits was justified by sufficient evidence despite the fact that it contradicted the opinions of plaintiff's treating physicians).

In his briefing, Plaintiff's two main arguments in support of overturning Defendant's decision to deny him disability benefits are that: (1) Defendant's decision is contrary to the opinions provided by Janmarie Forward, a Black & Decker employee, in a Work Capacity Evaluation and (2) Defendant's decision credits the medical opinions of an independent medical examiner over the opinions of his Plaintiff's treating physicians. *See* Plaintiff's Motion at 11-19.

In making these arguments, Plaintiff essentially argues that Defendant's decision was based on factual findings which were clearly erroneous. It is clear under *Snow*, however, that the fact that Defendant's decision contradicts some evidence in the administrative record is not sufficient to overturn Defendant's decision. Consequently, the fact that an individual like Ms. Forward who apparently lacks any expertise or credentials in medicine, disability evaluation, and vocational evaluation has

expressed an opinion contrary to Defendant's ultimate decision is not sufficient reason to overturn Defendant's decision given the other evidence in the administrative record.[2] Furthermore, it is also clear that Defendant need not credit the opinion of Plaintiff's treating physician over the opinions of an independent medical examiner. *See Voight v. Metropolitan Life Insurance Co.*, 28 F.Supp.2d 569, 578-81 (C.D.Cal. 1998) (Morrow, J.) (citing other cases), *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 63 F.Supp.2d 1145, 1161-64 (C.D.Cal. 1999) (Collins, J.) (citing other cases). This is especially the case when MetLife gave Plaintiff and Plaintiff's treating physicians an opportunity to comment on the independent medical examiner's opinions, *see* Brusca Decl. Exh. D. at

[2] Item 6 of the Work Capacity Evaluation reads as follows:

> Dr. Mitri describes Kenneth Nord as suffering from degenerative disc disease and a chronic myofascial pain syndrome. You have indicated in your employer statement provided to Metropolitan that the work of a material planner requires continuous interpersonal relationships and frequent exposure to stressful job situations. Assume that Kenneth Nord would have a moderate pain that would interfere with his ability to perform intense interpersonal communications or to act appropriately under stress occasionally (up to one-third) during the day. Could [an] individual of those limitations perform the work of a material planner?" Brusca Decl, Exh. C at 40.

Ms. Forward responded "no" to Item 6. *Id.* furthermore, in its October 27, 1998 denial letter, Black & Decker specifically referenced Ms. Forward's response in the Work Capacity Evaluation and stated "The results of that evaluation are not sufficient to reverse our decision." Brusca Dec, Exh. D. at 159. Furthermore, as Defendant persuasively argued at the hearing on the instant Motions, Ms. Forward's response to Item 6 of the Work Capacity Evaluation did not take account of the prescription painkillers Plaintiff had been taking virtually since the onset of his lower back pain in early 1997.

159, and Plaintiff apparently never took advantage of this opportunity. *Cf. Dames*, 49 F.Supp.2d at 1202 (fact that administrator did not consider untimely submitted medical opinions is not evidence of taint sufficient to invoke de novo review because of conflict of interest; decision not to consider untimely evidence was exactly the kind of exercise of discretionary authority which administrator was entitled to make).

Finally, at the hearing on the instant Motions, Plaintiff's counsel emphasized a conversation between the Plan Manager, Raymond Brusca, and Ms. Forward, the Black & Decker human resources employee who provided responses on a Work Capacity Evaluation sent to Black & Decker by Plaintiff. Although Defendant admits that a conversation took place, Defendant has not disclosed the exact details of the conversation. In his declaration, Mr. Brusca does state that he discussed the specific duties of the Material Planner position, the freedom of movement Plaintiff had in that position, and the availability of aid to Plaintiff in lifting in that position if aid were necessary. Brusca Decl. ¶17.

At the hearing, Plaintiff's counsel pointed to this conversation both as evidence sufficient to meet Plaintiff's burden of demonstrating an actual conflict of interest and as evidence of an abuse of discretion on Defendant's part. The Court disagrees. Given Ms. Forward lack of expertise or credentials, her responses in the Work Capacity Evaluation cannot be said to constitute material evidence as Plaintiff claims. Consequently, any conversation between Mr. Brusca and Ms. Forward whether disclosed or undisclosed also cannot constitute evidence sufficient to demonstrate an actual conflict of interest or an abuse of discretion.

In sum, because an administrator's decision is not based on clearly erroneous factual findings when it conflicts with some evidence in the administrative record and because Defendant need not credit the opinions of Plaintiff's treating physicians over those of an independent medical examiner, the Court holds that Defendant did not abuse its discretion in denying Plaintiff's claim for benefits. *See Snow*, 87 F.3d at 331-32, *Voight*, 28 F.Supp.2d at 578-81, *Jordan*, 63 F.Supp.2d at 1161-64, *see also* Defendant's Opposition at 16-23, Defendant's Reply at 6-11, Defendant's Motion at 7-17.

IV.

Conclusion

For the foregoing reasons, the Court finds that Defendant has met its burden on summary judgment of demonstrating that there is no genuine dispute of material fact and that it is entitled to judgment as a matter of law. Also for the foregoing reasons, the Court finds that Plaintiff has not met his burden on summary judgment of demonstrating that there is no genuine dispute of material fact and that he is entitled to judgment as a matter of law. Therefore, the Court hereby *grants* Defendant's Motion for Summary Judgment and hereby *denies* Plaintiff's Motion for Summary Judgment.

IT IS SO ORDERED.

DATED: March 22, 2000.

/s/ Carlos R. Moreno
Carlos R. Moreno
United States District Judge

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29 U.S.C. § 1132(a)(1)(B) (2002)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

* * *

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28 U.S.C. § 1254(1)

§ 1254. Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

* * *

[LOGO]

U.S. Department of Labor

Pension and Welfare
Benefits Administration
www.dol.gov/pwba

September 4, 2002
Benefit Claims Procedure Regulation

On November 21, 2000, the Department of Labor published in the Federal Register a final regulation that sets new standards for processing benefit claims of participants and beneficiaries who are covered under employee benefit plans governed by the Employee Retirement Income Security Act of 1974.

The new claims procedure regulation will begin to apply to some plans for new claims filed on or after January 1, 2002. It will not begin to apply to group health plans until the first day of the first plan year beginning on or after July 1, 2002, but not later than January 1, 2003. See 66 FR 35886 (July 9, 2001).

The claims procedure regulation changes the minimum procedural requirements for the processing of benefit claims for all employee benefit plans covered under ERISA, although the changes are minimal for pension and welfare benefit plans other than those that provide group health and disability benefits. For group health and disability benefit claims, the regulation substantially changes the procedures for benefit determinations. Among other things, it creates new procedural standards for initial and appeal-level decisions, new time frames for decision making, and new disclosure rights for claimants.

Since publication, the department has received many questions on how to apply the provisions of the new regulation. This document answers many of the frequently asked questions about the application of the regulation to group health and disability benefit plans. To the extent that the provisions of the regulation discussed below apply to other types of plans, the guidance provided in this document applies to those plans also. The department is publishing this guidance to assist plans in bringing their benefit processing systems into timely compliance with the new requirements. The department anticipates providing additional guidance in the form of additional questions and answers, advisory opinions, or information letters as may be necessary to facilitate implementation of the requirements of the regulation. The views expressed in this publication represent the views of the Department of Labor.

A-1: Does the regulation apply to benefit claims filed by enrollees in federal programs, such as Medicare and Medicaid, or to federal employees and their families covered under the Federal Employees Health Benefits Program (FEHBP)?

No. The regulation establishes requirements only for employee benefit plans that are covered under ERISA. See ERISA sections 3(1) and 3(2). Such plans are typically benefit programs provided by private-sector employers for their employees (or by unions, acting either independently or jointly with employers, for their members). Government programs, whether federal, state, or local, that are not related to employment, such as Medicaid and Medicare, are not covered by these claims procedure rules; neither are government-sponsored benefit programs for governmental employees, such as the FEHBP or benefit plans

provided by state or local governments to their own employees. Such plans have their own specific rules for claims procedures, which may derive from other federal law (for federal programs) or from state or local law.

A-2: Does the regulation apply to benefit claims filed by persons who are both enrollees in Medicare + Choice programs and participants in an ERISA plan?

The regulation applies only to benefits provided under an ERISA plan that are outside the scope of what is regulated by the Medicare program. Benefits provided under ERISA plans vary from plan to plan based on plan design. When a benefit is provided under an ERISA plan pursuant to a separate group arrangement between the Medicare + Choice organization and the employer (or employee organization), even though the benefit is only available to enrollees in a Medicare + Choice program, we have been advised by HHS that the benefit would be outside the scope of what is regulated by the Medicare program. Claims for such benefits would be subject to the provisions of the regulation. The primary source of information about these ERISA benefits is the summary plan description for the plan, which is available on request from the plan administrator. On the other hand, benefits that are covered under a Medicare + Choice contract (whether they are Medicare benefits, additional benefits paid for by Medicare, or supplemental benefits paid for through a premium charged to all enrollees) are subject to the Medicare + Choice rules for organization determinations, appeals, and grievances under 42 CFR 422 and not the provisions of the regulation. See question A-1. A person who is covered by a

Medicare + Choice program and wants more information on how these Medicare + Choice rules apply to his or her coverage should call 1.800.Medicare. He or she may also want to consult their Medicare Regional Office and 1.800.Medicare can assist them in contacting the appropriate office.

A-3: Does the regulation apply to a request for a determination whether an individual is eligible for coverage under a plan?

The regulation applies to coverage determinations only if they are part of a claim for benefits. The regulation, at § 2560.503-1(e), defines a claim for benefits, in part, as a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. A claim for group health benefits includes pre-service claims (§ 2560.503-1(m)(2)) and post-service claims (§ 2560.503-1(m)(3)). If an individual asks a question concerning eligibility for coverage under a plan without making a claim for benefits, the eligibility determination is not governed by the claims procedure rules. If, on the other hand, the individual files a claim for benefits in accordance with the plan's reasonable procedures, and that claim is denied because the individual is not eligible for coverage under the plan, the coverage determination is part of a claim and must be handled in accordance with the claims procedures of the plan and the requirements of the regulation. See 65 FR at 70255.

A-4: Does the regulation apply to a request for prior approval of a benefit or service when such prior approval is not required under the terms of the plan?

No. If the plan does not require prior approval for the benefit or service with respect to which the approval is being requested, the request is not a claim for benefits (§ 2560.503-1(e)) governed by the regulation. The regulation defines pre-service claim by reference to the plan's requirements, not the claimant's decision to seek the medical care, nor the doctor's decision to provide care. Thus, in the absence of any plan requirement for prior approval, mere requests for advance information on the plan's possible coverage of items or services or advance approval of covered items or services do not constitute pre-service claims under the regulation. See § 2560.503-1(m)(2).

A-5: Is a plan required to treat all questions regarding benefits as claims for benefits under the plan?

No. The regulation does not govern casual inquiries about benefits or the circumstances under which benefits might be paid under the terms of a plan. On the other hand, a group health plan that requires the submission of pre-service claims, such as requests for preauthorization, is not entirely free to ignore pre-service inquiries where there is a basis for concluding that the inquirer is attempting to file or further a claim for benefits, although not acting in compliance with the plan's claim filing procedures. In such a case, the regulation requires the plan to inform the individual of his or her failure to

file a claim and the proper procedures to be followed. Specifically, this type of notification is required where there is a communication by a claimant or authorized representative (e.g., attending physician) that is received by a person or organizational unit customarily responsible for handling benefit matters (e.g., personnel office) and that communication names the specific claimant, specific medical condition or symptom and a specific treatment, service, or product for which approval is requested. Under the regulation, notice must be furnished as soon as possible, but not later than 24 hours in the case of urgent care claims or 5 days in the case of non-urgent claims. Notice may be oral, unless a written notification is requested. See § 2560.503-1(c)(1).

A-6: Do the requirements applicable to group health plans apply to dental benefits offered as a stand-alone plan or as part of a group heath plan?

Yes, in both cases. The regulation defines group health plan as an employee welfare benefit plan within the meaning of ERISA section 3(1) to the extent that such plan provides medical care within the meaning of section 733(a) of ERISA. See § 2560.503-1(m)(6). Section 733(a)(2) defines medical care, in part, to mean the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body. Accordingly, for purposes of the claims procedure rules, the provision of dental benefits, either as part of a larger welfare plan, or as a stand-alone plan, would be subject to the requirements of the regulation applicable to group health plans.

A-7: Do the requirements applicable to group health plans apply to prescription drug benefit programs offered as a stand-alone plan or as part of a group health plan?

Yes, in both cases. Prescription drug benefits would, like dental benefits, constitute medical care within the meaning of Section 733(a)(2). See question A-6. Accordingly, the provision of prescription drug benefits, either as a stand-alone plan, or as part of a group health plan, would be subject to the requirements of the regulation applicable to group health plans. Whether, and under what circumstances, specific practices permitted under the plan, such as the submission of a prescription to a pharmacy or pharmacist, will constitute a claim for benefits governed by the claims procedure rules will depend on the terms of the plan.

A-8: Do the requirements applicable to group health plans apply to contractual disputes between health care providers (e.g., physicians, hospitals) and insurers or managed care organizations (e.g., HMOs)?

No, provided that the contractual dispute will have no effect on a claimant's right to benefits under a plan. The regulation applies only to claims for benefits. See questions A-3, A-4, A-5. The regulation does not apply to requests by health care providers for payments due them – rather than due the claimant – in accordance with contractual arrangements between the provider and an insurer or managed care organization, where the provider has no recourse against the claimant for amounts, in

whole or in part, not paid by the insurer or managed care organization.

The following example illustrates this principle. Under the terms of a group health plan, participants are required to pay only a $10 co-payment for each office visit to a preferred provider doctor listed by a managed care organization that contracts with such doctors. Under the preferred provider agreement between the doctors and the managed care organization, the doctor has no recourse against a claimant for amounts in excess of the co-payment. Any request by the doctor to the managed care organization for payment or reimbursement for services rendered to a participant is a request made under the contract with the managed care organization, not the group health plan; accordingly, the doctor's request is not a claim for benefits governed by the regulation.

On the other hand, where a claimant may request payments for medical services from a plan, but the medical provider will continue to have recourse against the claimant for amounts unpaid by the plan, the request, whether made by the claimant or by the medical provider (e.g., in the case of an assignment of benefits by the claimant) would constitute a claim for benefits by the claimant. For information on authorized representatives of claimants. See questions B-1, B-2, B-3.

A-9: What benefits are disability benefits subject to the special rules applicable under the regulation for disability claims?

A benefit is a disability benefit under the regulation, subject to the special rules for disability claims, if the plan

conditions its availability to the claimant upon a showing of disability. It does not matter how the benefit is characterized by the plan or whether the plan as a whole is a pension plan or a welfare plan. If the claims adjudicator must make a determination of disability in order to decide a claim, the claim must be treated as a disability claim for purposes of the regulation. As the department stated in the preamble to the regulation, 65 FR at 70247, n.4, where a single plan provides more than one type of benefit, it is the department's intention that the nature of the benefit should determine which procedural standards apply to a specific claim, rather than the manner in which the plan itself is characterized. Accordingly, plans, including pension plans, that provide benefits conditioned upon a determination of disability must maintain procedures for claims involving such benefits that comply with the requirements of the regulation applicable to disability claims, including the requirements for de novo review, the consultation requirement for medical judgments, the limit on appeal levels, the time limits for deciding disability claims, and the disclosure requirements in connection with extensions of time.

However, if a plan provides a benefit the availability of which is conditioned on a finding of disability, and that finding is made by a party other than the plan for purposes other than making a benefit determination under the plan, then the special rules for disability claims need not be applied to a claim for such benefits. For example, if a pension plan provides that pension benefits shall be paid to a person who has been determined to be disabled by the Social Security Administration or under the employer's long term disability plan, a claim for pension benefits based on the prior determination that the claimant is

disabled would be subject to the regulation's procedural rules for pension claims, not disability claims.

A-10: Do the time frames in these rules govern the time within which claims must be paid?

No. While the regulation establishes time frames within which claims must be decided, the regulation does not address the periods within which payments that have been granted must be actually paid or services that have been approved must be actually rendered. Failure to provide services or benefit payments within reasonable periods of time following plan approval, however, may present fiduciary responsibility issues under Part 4 of title I of ERISA.

A-11: When a group health plan participant presents a prescription to a pharmacy to be filled at a cost to the participant determined by reference to a formula or schedule established in accordance with the terms of such plan and with respect to which the pharmacy exercises no discretion on behalf of the plan, does the regulation require that the presentation of the prescription be treated as a claim for benefits?

No. As indicated in question A-7, whether, and under what circumstances, specific practices permitted under a plan, such as the presentation of a prescription to a pharmacy, will constitute a claim for benefits governed by the claims procedure rules will depend on the terms of the plan. In this regard, a claim for benefits is defined in § 2560.503-1(e) to

mean a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. Accordingly, whether, and to what extent, the presentation of a prescription to a pharmacy which exercises no discretion on behalf of the plan will constitute a request for a plan benefit will be determined by reference to the plan's procedures for filing benefit claims.

It is not uncommon for group health plans to have arrangements with preferred or network providers (e.g., doctors, physical therapists, pharmacies, optometrists) to provide medical care-related services or products at a predetermined cost to covered plan participants and with respect to which the providers exercise no discretion on behalf of the plan. It is the view of the department that neither the statute nor the claims procedure regulation requires that a plan treat interactions between participants and preferred or network providers under such circumstances as a claim for benefits governed by the regulation. Moreover, if the pharmacy refuses to fill the prescription absent payment of the entire cost by the participant, the regulation does not require that this refusal be treated as an adverse benefit determination under the regulation. It should be noted, however, that where a plan provides such benefits the plan must maintain a reasonable procedure, in accordance with the regulation, for processing claims of participants relating to such benefits.

A-12: Does the regulation apply to benefit claims filed by participants in top hat plans, e.g., plans that are unfunded and maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees?

Yes. The regulation establishes requirements for all employee benefit plans that are covered under Part 5 of ERISA, which would include top hat plans. Certain top hat plans are specifically excluded from parts of ERISA (see, e.g., sections 201(2); 301(a)(3); 401(a)(1)), but that exclusion does not apply to section 503, under which the regulation was promulgated. In this regard, paragraph (b)(2) of the regulation requires that a description of the plan's claims procedures must be included as part of the plan's summary plan description meeting the requirements of 29 CFR § 2520.102-3. Where a top hat plan is not required to furnish summary plan descriptions, pursuant to 29 CFR §§ 2520.104-23 or 2520.104-24, such plan may satisfy the requirements of paragraph (b)(2) of the regulation by taking steps reasonably designed to ensure that participants in such plans are made aware of the existence of the plan's claims procedures in conjunction with enrollment in the plan and how to obtain such procedures upon request.

A-13: Would a determination of disability for purposes of receiving a premium waiver under a contributory life insurance plan be governed by the special rules applicable to disability benefits under the claims procedure regulation?

Yes. A benefit is a disability benefit under the regulation, subject to the special rules for disability claims, if the plan conditions availability of the benefit on a showing of disability. As noted in question A-9, however, if a plan provides a benefit the availability of which is conditioned on a finding of disability, and that finding is made by a party other than the plan for purposes other than making a benefit determination under the plan, then the special rules for disability claims need not be applied to a claim for such benefits. The department notes that the inclusion of a premium waiver in a plan that is not otherwise covered by ERISA would not, in and of itself, cause the plan to become subject to the regulation.

B-1: May a plan require that a claimant complete and file a form identifying any person authorized to act on his or her behalf with respect to a claim?

Yes, with one exception. The regulation provides that a reasonable claims procedure may not preclude an authorized representative of a claimant from acting on behalf of a claimant with respect to a benefit claim or appeal of an adverse benefit determination. The regulation also provides, however, that a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the claimant. Completion of a form by the claimant identifying the authorized

representative would be one method for making such a determination.

The one exception is where a claim involves urgent care. In such instances, a plan must, without regard to the plan's procedures for identifying authorized representatives, permit a health care professional with knowledge of the claimant's medical condition (e.g., a treating physician) to act as the authorized representative of the claimant. This exception is intended to enable a health care professional to pursue a claim on behalf of a claimant under circumstances where, for example, the claimant is unable to act on his or her own behalf. See § 2560.503-1(b)(4).

B-2: Does an assignment of benefits by a claimant to a health care provider constitute the designation of an authorized representative?

No. An assignment of benefits by a claimant is generally limited to assignment of the claimant's right to receive a benefit payment under the terms of the plan. Typically, assignments are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan. In addition, the validity of a designation of an authorized representative will depend on whether the designation has been made in accordance with the procedures established by the plan, if any.

B-3: When a claimant has properly authorized a representative to act on his or her behalf, is the plan required to provide benefit determinations and other notifications to the authorized representative, the claimant, or both?

Nothing in the regulation precludes a plan from communicating with both the claimant and the claimant's authorized representative. However, it is the view of the department that, for purposes of the claims procedure rules, when a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a claim, the plan should, in the absence of a contrary direction from the claimant, direct all information and notifications to which the claimant is otherwise entitled to the representative authorized to act on the claimant's behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, etc.). In this regard, it is important that both claimants and plans understand and make clear the extent to which an authorized representative will be acting on behalf of the claimant.

B-4: What kind of administrative processes and safeguards must a plan have in place to ensure and verify appropriately consistent decision making?

The department did not intend to prescribe any particular process or safeguard to ensure and verify consistent decision making by plans. To the contrary, the department intended to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with the prudent administration of a plan. The

department believes that prudent plan administration requires ensuring that similarly situated claims are, under similar circumstances, decided in a consistent manner. Consistency in the benefit claims determinations might be ensured by applying protocols, guidelines, criteria, rate tables, fee schedules, etc. Consistent decision making might be ensured and verified by periodic examinations, reviews, or audits of benefit claims to determine whether the appropriate protocols, guidelines, criteria, rate tables, fee schedules, etc. were applied in the claims determination process. See § 2560.503-1(b)(5).

B-5: For purposes of furnishing relevant documents to a claimant, what kind of disclosure is required to demonstrate compliance with the administrative processes and safeguards required to ensure and verify appropriately consistent decision making in making the benefit determination?

What documents will be required to be disclosed will depend on the particular processes and safeguards that a plan has established and maintains to ensure and verify appropriately consistent decision making. See 65 FR at 70252. The department does not anticipate new documents being developed solely to comply with this disclosure requirement. Rather, the department anticipates that claimants who request this disclosure will be provided with what the plan actually used, in the case of the specific claim denial, to satisfy this requirement. The plan could, for example, provide the specific plan rules or guidelines governing the application of specific protocols, criteria, rate tables, fee schedules, etc. to claims like the claim at issue, or the specific checklist or cross-checking

document that served to affirm that the plan rules or guidelines were appropriately applied to the claimant's claim. Plans are not required to disclose other claimants' individual records or information specific to the resolution of other claims in order to comply with this requirement. See § 2560.503-1(m)(8)(iii). See question D-12.

B-6: Do the regulation's limits on the use of pre-dispute arbitration extend to other actions that a participant or beneficiary might pursue with regard to a health care provider or other person or entity?

No. The regulation is intended to regulate pre-dispute arbitration only with respect to group health and disability benefits provided under ERISA-covered plans. The regulation is not intended to affect the enforceability of a pre-dispute arbitration agreement with respect to any other claims or disputes. Accordingly, the regulation should not be read to affect the obligation of a participant or beneficiary to arbitrate such other claims and disputes within the scope of the arbitration agreement. See 29 CFR § 2560.503-1(c)(3)(iii).

C-1: When does the time period for making an initial decision on a claim begin to run?

The time for making an initial claims decision begins to run when the claim is filed in accordance with a plan's reasonable filing procedures, regardless of whether the plan has all of the information necessary to decide the claim at the time of the filing.

For purposes of calculating the time period within which a claim must be decided, a plan cannot extend the time period by treating as filed only those claims with respect to which all the information necessary to make a decision has been submitted (often referred to as clean claims). See § 2560.503-1(f)(4).

C-2: May a plan's claims procedures require claimants to submit relevant medical information or information relating to coordination of benefits prior to the plan's making a decision on a claim?

Plans have considerable flexibility in defining the procedures to be followed for the initiation, processing, and appeal of benefit claims. However, while plans may require the submission of specific information necessary to a benefit determination under the terms of the plan, including medical and coordination of benefit information, the plan may nonetheless have to make a decision on the claim before receiving such information. As noted in question C-1, the time periods applicable to deciding claims begin to run on the date a claim is filed in accordance with reasonable procedures of the plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. See § 2560.503-1(f)(4).

C-3: If the period within which a group health claim must be decided is ending and the claimant has yet to furnish all the information necessary to decide the claim, may the plan extend the time period for deciding the claim and, if so, for how long?

In general, a group health plan may unilaterally extend the decision making on both pre-service and post-service claims for 15 days after the expiration of the initial period, if the administrator determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care.

If the reason for taking the extension is the failure of the claimant to provide information necessary to decide the claim, and the claimant is so notified of this fact, the time period for making the decision is suspended (tolled) from the date of the notification to the claimant to the earlier of:

> The date on which a response from the claimant is received by the plan
>
> The date established by the plan for the furnishing of the requested information (at least 45 days)

The extension period (15 days) – within which a decision must be made by the plan – will begin to run from the date on which the claimant's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days). See §§ 2560.503-1(f)(2)(iii) (A) and (B); 2560.503-1(f)(4); 2560.503-1(i)(4). Also see 65 FR at 70250, n.21.

C-4: Many plans, including group health and disability plans, require claimants to submit to examination by an expert or experts of the plan's choosing in connection with the plan's consideration of the claimant's claim. How do the regulation's time limits apply to the completion of such examinations?

The regulation's time limits begin to run when a claim is filed in accordance with the reasonable procedures of the plan for filing claims. See question C-1. A plan that requires a physical or other examination of the claimant to evaluate a claim must design a process that provides for decision making within the time frames of the regulation.

If necessary, however, in the circumstances of a specific claim, a plan may take an extension of time to enable the claimant to submit requested information (including the report of a required examination). The regulation's provisions on extensions of time and tolling, discussed in question C-3, would apply to these situations to determine when an extension is permitted and when an extension would begin and end. Under those rules, when a plan takes an extension of time because additional information must be obtained from a claimant, the claimant must be provided at least 45 days within which to provide the information or submit to the requested examination. Plans may, of course, provide claimants longer periods of time for this purpose.

C-5: May a claimant agree to an extension or further extension of the time period within which a plan must decide a claim?

Yes. The only limits on extensions of time established by the regulation are imposed on plans. Claimants may voluntarily agree to provide a plan additional time within which to make a decision on a claim, even under circumstances where the plan could not unilaterally extend the decision making period, such as in the case of a claim involving urgent care or a claim on appeal.

See §§ 2560.503-1(f)(2)(i); 2560.503-1(i). Also see 65 FR at 70250, n.21.

C-6: What responsibility does the plan have for determining whether any specific claim involves urgent care and must therefore be decided on an expedited basis?

A plan has a duty to make this determination on the basis of the information provided by, or on behalf of, the claimant. A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or – in the opinion of a physician with knowledge of the claimant's medical condition – would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim must be treated as an urgent care claim. See § 2560.503-1(m)(1).

C-7: Under the regulation, urgent care claims must be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt, and pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt. Can a plan's claims procedures require claimants to explain or describe whether, and what, medical exigencies or medical circumstances exist?

Yes. While the department has indicated that the time periods for decision making are generally maximum periods and not automatic entitlements, the department recognizes that assessments of the appropriate timeframe for making benefit determinations will, in large part, be dependent on the information provided by the claimant. Requesting specific information from the claimant regarding whether and what medical circumstances exist that may give rise to a need for expedited processing of the claim would appear to facilitate claims processing and, therefore, would not, in the view of the department, be an unreasonable plan request. If, on the other hand, the plan believes based on its own review of the claim that expedited processing is required, it is the view of the department that

the claim must be processed on an expedited basis without regard to the claimant's failure to provide information relating to whether expedited processing is necessary.

C-8: If a claimant requests a plan to extend a previously approved course of treatment, by either increasing the number of treatments or the period of time for treatments, and that request is determined by the claimant's treating physician to be a claim involving urgent care, within what period must the plan approve or deny the claimant's request?

Under the concurrent care provisions of the rule, any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical exigencies, and notification must be provided to the claimant within 24 hours after receipt of the claim, when the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If such a request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, i.e., as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt. See § 2560.503-1(f)(2)(i) and (ii) (B).

If a request to extend a course of treatment beyond the period of time or number of treatments previously approved

by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, i.e., as a pre-service claim or a post-service claim. § 2560.503-1(f)(2)(iii).

C-9: In the case of a group health plan's decision to reduce or terminate a previously approved course of treatment, must claimants be afforded at least 180 days to appeal the plan's revised determination before the benefit can be reduced or terminated?

No. Under the concurrent care provisions of the rule, any reduction or termination of a course of treatment (other than by plan amendment) before the end of the previously approved period or number of treatments is treated as an adverse benefit determination. In such cases the rule requires that the plan administrator provide the claimant sufficient advance notice of the reduction or termination to allow the claimant to appeal and obtain a determination before the benefit is reduced or terminated. Generally, claimants must be afforded at least 180 days following an adverse benefit determination to appeal that determination. If the 180 day rule applied to appeals under concurrent care provisions of the regulations, notifications of reductions or terminations would, in every instance, have to be given at least six months in advance of the termination or reduction. This was not the intention of the department. Accordingly, while the department is of the view that plans must afford claimants a reasonable period of time within which to develop their appeal of a proposed reduction or termination, plans are not required to assume that claimants will need the full 180 days to file such an

appeal before the benefit can be reduced or terminated under the special rules governing concurrent care claims. See § 2560.503-1(f)(2)(ii) (A).

C-10: In what circumstances, if any, would a post-service claim be a claim involving urgent care?

Post-service claims are those claims with respect to which plan approval is not a prerequisite to obtaining medical services and payment is being requested for medical care already rendered to the claimant. Accordingly, a post-service claim would never constitute a claim involving urgent care within the meaning of the regulation.

A post-service claim is defined in the regulation as any claim for a benefit under a group health plan that is not a pre-service claim. Pre-service claims are those claims with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. See question C-6, § 2560.503-1(m)(1), (2), and (3).

C-11: If a claim is determined to involve urgent care when it is initially filed, must it automatically continue to be treated as urgent if it is denied and the claimant files an appeal, regardless of whether, at that time, medical services have actually been provided and the only question to be resolved is who will pay for such services?

No. The nature of a claim or a request for review of an adverse benefit determination should be judged as of the

time the claim or review is being processed. If requested services have already been provided between the time the claim was denied and a request for review is filed, the claim no longer involves urgent care because use of the post-service time frames for deciding the appeal could not jeopardize the claimant's life, health, or ability to regain maximum function, or subject the claimant to severe pain. See § 2560.503-1(m)(1).

C-12: If a claimant submits medical bills to a plan for reimbursement or payment, and the plan, applying the plan's limits on co-payment, deductibles, etc., pays less than 100% of the medical bills, must the plan treat its decision as an adverse benefit determination?

Under the regulation, an adverse benefit determination generally includes any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In any instance where the plan pays less than the total amount of expenses submitted with regard to a claim, while the plan is paying out the benefits to which the claimant is entitled under its terms, the claimant is nonetheless receiving less than full reimbursement of the submitted expenses. Therefore, in order to permit the claimant to challenge the plan's calculation of how much it is required to pay, the decision is treated an adverse benefit determination under the regulation. Providing the claimant with the required notification of adverse benefit determination will give the claimant the information necessary to understand why the plan has not paid the unpaid portion of the expenses and to decide whether to challenge the denial, e.g., the failure to pay in

full. This approach permits claimants to challenge whether, for example, the plan applied the wrong co-payment requirement or deductible amount. The fact that the plan believes that a claimant's appeal will prove to be without merit does not mean that the claimant is not entitled to the procedural protections of the rule. This approach to informing claimants of their benefit entitlements with respect to specific claims, further, is consistent with current practice, in which Explanation of Benefits forms routinely describe both payable and non-payable portions of claim-related expenses. See § 2560.503-1(m)(4).

C-13: Under what circumstances is a plan required to notify a claimant of a benefit determination that is not an adverse benefit determination, i.e., a complete grant of a claim?

In the case of urgent care claims and pre-service claims, the regulation requires that claimants be apprised of the plan's benefit determination, whether the determination is adverse or a complete grant. The rules require that this notification be furnished in accordance with the time-frames generally applicable to urgent care and pre-service claims. There is no specific notification requirement applicable to post-service claims that are fully granted. See § 2560.503-1(f)(2)(i) and (iii).

C-14: What information is a plan required to provide when giving notice of a claim determination that is not adverse (that has been completely granted), in the case of an urgent care or pre-service claim?

The regulation does not specify the information that must be provided in notices of benefit determinations that are not adverse. However, in accordance with the regulation's general requirement of reasonableness, the department anticipates that such notices will contain sufficient information to fully apprise the claimant of the plan's decision to approve the requested benefits. See § 2560.503-1(f)(2)(i) and (iii) (A).

C-15: When a plan has approved a benefit that will be provided over a period of time, such as a series of chemotherapy treatments, must the plan notify the claimant when the benefits end?

No. Provided that the plan complied with the regulation in adequately notifying the claimant regarding the scope of the benefit that was originally approved (e.g., for how long, how many treatments, etc.) and further provided that the plan has not decided to reduce or terminate early the course of treatment that was previously approved, the regulation does not require the plan to provide a formal notification that the course of treatment is coming to an end. See § 2560.503-1(f)(2)(ii).

C-16: May a notice of an adverse benefit determination generally state that a rule, guideline or protocol may have been relied upon in making the benefit determination and satisfy the requirements of the regulation?

No. The regulation provides that if an internal rule, guideline, protocol, or similar criterion was relied upon in making an adverse benefit determination, the notification of the adverse benefit determination must either set forth the rule, guideline, protocol, or criterion or indicate that such was relied upon and will be provided free of charge to the claimant upon request. It would be sufficient, in the view of the department, in such a case, to indicate that an internal rule, etc., had been relied upon without specifying the identity of the specific rule and that the specific rule, etc. would be furnished to the claimant upon request. A notice that merely indicates, however, that a rule, guideline, protocol, or similar criterion may have been relied upon does not provide the claimant any specific information about the basis on which his or her claim was decided. Inasmuch as plans will know in every instance what rules, protocols, guidelines, etc. were relied upon in making a determination, providing an indication whether such was relied upon should not be difficult. Moreover, the department is concerned that the routine inclusion of such a statement in all adverse benefit determination notifications may undermine the significance of the required disclosure. See § 2560.503-1(g)(1)(v) (A). For similar reasons, a general statement in an adverse benefit determination notice would not be considered as satisfying the requirements of § 2560.503-1(g)(1)(v) (B). Also see § 2560.503-1(j)(5)(i) and (ii).

C-17: Is a plan required to provide a copy of an internal rule, guideline, protocol, or similar criterion when the applicable rule, guideline, protocol, or criterion was developed by a third party which, for proprietary reasons, limits the disclosure of that information?

Yes. It is the view of the department that where a rule, guideline, protocol, or similar criterion serves as a basis for making a benefit determination, either at the initial level or upon review, the rule, guideline, protocol, or criterion must be set forth in the notice of adverse benefit determination or, following disclosure of reliance and availability, provided to the claimant upon request. However, the underlying data or information used to develop any such rule, guideline, protocol, or similar criterion would not be required to be provided in order to satisfy this requirement. The department also has taken the position that internal rules, guidelines, protocols, or similar criteria would constitute instruments under which a plan is established or operated within the meaning of section 104(b)(4) of ERISA and, as such, must be disclosed to participants and beneficiaries. See §§ 2560.503-1(g)(v)(A) and (j)(5)(i); 65 FR at 70251. Also see §§ 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8)(i); Advisory Opinion 96-14A (July 31, 1996).

C-18: If a plan conditions continuation of disability benefit payments on a periodic confirmation of the claimant's disability and, in conjunction with such a confirmation, determines that the claimant is no longer disabled and, accordingly, terminates payment of benefits, must the plan treat the termination as an adverse benefit determination under the regulation?

Yes. Under the regulation, an adverse benefit determination includes any denial, reduction, or termination of a benefit. Accordingly, where a plan terminates the payment of disability benefits under such circumstances, the plan is required to provide the claimant a notification of adverse benefit determination and the right to appeal that determination consistent with the regulation. See 29 CFR § 2560.503-1(m)(4), (g) and (h). If, on the other hand, a plan provides for the payment of disability benefits for a pre-determined, fixed period (e.g., a specified number of weeks or months or until a specified date), the termination of benefits at the end of the specified period would not constitute an adverse benefit determination under the regulation. Any request by a claimant for payment of disability benefits beyond the specified period, therefore, would constitute a new claim. See 29 CFR § 2560.503-1(f)(3). Also see 29 CFR § 2560.503-1(f)(2)(ii).

C-19: Does the regulation limit a plan's ability to establish a maximum period for the filing of initial claims for benefits?

No. The regulation does not contain any specific rules governing the period of time that must be given to claimants

to file their claims. However, a plan's claim procedure nonetheless must be reasonable and not contain any provision, or be administered in any way, that unduly inhibits or hampers the initiation or processing of claims for benefits. Adoption of a period of time for filing claims that serves to unduly limit claimants' reasonable, good faith efforts to make claims for and obtain benefits under the plan would violate this requirement. See 29 CFR § 2560.503-1(b)(3).

C-20: What timeframes apply when an extension of time is required by a plan in connection with an initial disability benefit determination?

The regulation addresses two situations in which a plan may have an extension of time for making a disability benefit determination. The first situation is when a decision cannot be rendered due to any matter beyond the control of the administrator other than the need for additional information from the claimant. In this situation, the extension period is added to the period within which the determination is required to be made. For example, if prior to the end of the initial 45-day period, the administrator determines that, for reasons beyond its control, a decision cannot be rendered, the plan may take up to an additional 30 days (i.e., 30 days in addition to the initial 45-day period). Similarly, if a decision cannot, for similar reasons, be rendered within the initial extension period, the plan may take up to an additional 30 days (i.e., 30 days in addition to the initial 30-day extension period) or up to a total of 105 days to decide the pending claim. See 29 CFR § 2560.503-1(f)(3). The second situation is when the plan requires additional information from the

claimant to make a benefit determination. This situation is governed by the principles in question C-3.

C-21: If a plan determines that a claim does not provide sufficient information, must the plan take an extension of time and request additional information from the claimant?

No. The provisions governing extensions of time are permissive and not mandatory. As such, plans may provide for taking extensions of time or not, and plan administrators may be given the discretion to decide whether to take an extension of time in connection with any individual claim. Consequently, as a general matter, a plan may deny claims at any point in the administrative process on the basis that it does not have sufficient information; such a decision would allow the claimant to advance to the next stage of the claims process.

C-22: If a group health plan determines that an extension of time is necessary in order to obtain additional information from a claimant, may the administrator as part of the notice to the claimant of the need for the extension of time also include a notice of adverse benefit determination applicable if the claimant fails to provide any information within the period prescribed by the plan (i.e., at least 45 days)?

Yes. If the notice clearly states that the claim will be denied if the claimant fails to submit any information in response to the plan's request, it is the view of the department that the

furnishing of a combined notice would not be contrary to the regulation, provided that the combined notice satisfied the content requirements applicable to both the extension notice and the notice of adverse benefit determination. In this regard, the notice of adverse benefit determination should make clear that the period for appealing the denied claim begins to run at the end of the period prescribed in the notice for submitting the requested information (or such later date as may be provided under the terms of the plan). See 29 CFR § 2560.503-1(f)(2) and (3).

D-1: May a plan require that requests for review of adverse benefit determinations be made in writing?

Yes, with one exception. The regulation provides that a plan's claims procedure must provide a claimant with a reasonable opportunity for a full and fair review of a denied claim. A claims procedure that requires requests for reviews of adverse benefit determinations to be made in writing would not be unreasonable in that regard, except with respect to claims involving urgent care. In the case of urgent care claims, the regulation requires that a plan's procedures permit requests for expedited appeals to be submitted orally or in writing by the claimant. See § 2560.503-1(h)(2) and (3)(vi).

D-2: May the direct supervisor of the person(s) who makes initial claim determinations serve as the appropriate named fiduciary for purposes of reviewing those claims on appeal?

Yes. The only limitation that the rule imposes on who can serve as the named fiduciary for purposes of reviewing adverse benefit determinations is that the named fiduciary cannot be either the individual who made the initial benefit determination that is the subject of the appeal or a subordinate of that individual. The rule further requires that the reviewer, whoever that individual is, may not afford deference to the initial determination. That is, the reviewer must consider the full record of the claim and make an independent decision on whether it should be granted. See § 2560.503-1(h)(3)(ii).

D-3: If a group health plan provides for two levels of review, rather than one, following an adverse benefit determination, what standards, if any, govern the second level of review?

Where a plan provides for two levels of review on appeal, it is the view of the department that the second level of review is subject to the same standards that apply to the first level of review. For example, the second-level reviewer may not afford deference to the decision at the first level of review, and the reviewer must not be the same person who made the first level review decision on the claim or a subordinate of that person. See §§ 2560.503-1(c)(2) and 2560.503-1(h)(3)(ii).

D-4: If a group health plan provides for two levels of review following an adverse benefit determination, within what period must a determination be made at each level?

In the case of pre-service claims, a maximum of 15 days is provided for a benefit determination at each level. In the case of post-service claims, a maximum of 30 days is provided for a determination at each level. See § 2560.503-1(i)(2)(ii) and (iii).

For example, if a claimant appeals a pre-service adverse benefit determination, and the plan provides for two levels of review at the appeal level, the plan must make a determination within a reasonable period of time, taking into account the medical circumstances, but no later than 15 days after receipt of the appeal. If that claim is again denied at the first level of appeal and the claimant appeals that denial to the second level review stage, the plan must again make a determination within a reasonable period of time, taking into account the medical circumstances, but not later than 15 days after the plan's receipt of the claimant's second level appeal request.

In the case of urgent care claims, the regulation does not prescribe any specific period within which a determination must be made at each level of a two-level review process for such claims. Given the principles underlying the provisions governing pre- and post-service claims, however, it is the view of the department that each level of review of an urgent care claim would have to be completed in sufficient time to ensure that the total period for completing the reviews would not exceed the maximum period otherwise applicable to a process with only one level of review – as soon as possible, taking into account the

medical exigencies, but not longer than 72 hours. See § 2560.503-1(i)(2)(i).

D-5: If a group health plan provides for two levels of review following an adverse benefit determination, how much time must a claimant be afforded to appeal the first level review determination to the second level review?

Under the regulation, claimants must be afforded at least 180 days following receipt of an adverse benefit determination to appeal that determination. In the case of a plan with a two-level review process, the 180-day rule applies to the period to be afforded claimants to appeal to the first review level. While the regulation does not specifically address the period of time to be afforded claimants to pursue the second level of review, the regulation requires that a plan's procedures must nonetheless be reasonable and, therefore, it is the view of the department that plans must afford claimants a reasonable opportunity to pursue a full and fair review at the second review level. See § 2560.503-1(h)(1) and (3)(i).

D-6: If a group health plan provides for two levels of review following an adverse benefit determination, may the plan use non-binding arbitration as a means for deciding the appealed claim?

Yes. A plan's procedures may provide for arbitration of benefit disputes at one of the two levels of appeal, provided two conditions are met. First, the arbitration must be conducted in a manner that will ensure that the timeframes

and notice requirements otherwise applicable to appeals will be satisfied. Second, the arbitration must be non-binding – that is, the arbitration may not limit the claimant's ability to challenge the benefit determination in court. See § 2560.503-1(c)(4). The regulation also permits a plan to offer binding arbitration to a claimant after completion of the plan's appeal process. See questions E-1 and E-2.

D-7: May the board of trustees or committee of a multi-employer group health plan or multi-employer disability benefit plan that generally reviews appealed benefit claims at their quarterly meetings provide for two levels of appeal consistent with the regulation?

Yes, under limited circumstances. In general, the regulation permits plans to maintain two levels of review for adverse benefit determinations and establishes special timing rules for making benefit decisions at each level of the review process. See §§ 2560.503-1(c)(2), 2560.503-1(i)(2)(ii) and (iii), 2560.503-1(i)(3). The regulation also provides special timing rules applicable to boards of trustees or committees of multi-employer group health plans and multi-employer disability benefit plans, pursuant to which such plans are excepted from the otherwise applicable timing requirements. Under these rules, such boards or committees generally are permitted to defer the decisions on adverse benefit determination appeals until the next regularly scheduled meeting of the plan's board or committee. See §§ 2560.503-1(i)(2)(iii) (B), 2560.503-1(i)(3)(ii). It is the view of the department that a multi-employer group health plan or a disability benefit plan

could not, in a manner consistent with the regulation, rely on both the special rules governing the maintenance of two appeal levels and the special rules for regularly scheduled boards of trustees or committee meetings. On the other hand, the department does not believe a multi-employer plan is foreclosed by the regulation from electing to make appeal determinations in accordance with the special rules governing two levels of appeal, rather than in accordance with the quarterly meeting provisions of the regulation. In addition, there is nothing in the regulation that would foreclose a multi-employer plan from making benefit review determinations in accordance with the quarterly meeting provisions and, following such determinations, providing claimants with an opportunity to voluntarily pursue an additional (second) review of their claim. See § 2560.503-1(c)(3).

D-8: Does the regulation's requirement of consultation with appropriate health care professionals limit the discretion of a plan fiduciary reviewing an adverse benefit determination with respect to the advice the fiduciary may seek in resolving the issues raised by the review?

The regulation requires, for group health and disability claims, that the fiduciary deciding an appeal of an adverse benefit determination based in whole or in part on a medical judgment consult with an appropriate health care professional. This requirement of consultation is intended to ensure that the fiduciary deciding a claim involving medical issues is adequately informed as to those issues. The consultation requirement, however, is not intended to constrain the fiduciary from consulting any other experts

the fiduciary considers appropriate under the circumstances. For example, in connection with the appeal of a denied disability claim, a fiduciary may consider it appropriate to consult with vocational or occupational experts. In all cases, a fiduciary must take appropriate steps to resolve the appeal in a prudent manner, including acquiring necessary information and advice, weighing the advice and information so obtained, and making an independent decision on the appeal. The regulation's provision for consultation with a health care professional is not intended to alter the fiduciary standards that apply to claims adjudication.

D-9: Under what circumstances must a group health plan (or disability benefit plan) disclose the identity of experts consulted in the course of deciding a benefit claim?

The regulation provides that, in order to allow claimants a reasonable opportunity for a full and fair review of their claim, a plan's claims procedures must provide for the identification of medical (or vocational) experts whose advice was obtained on behalf of the plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the determination. Under the rules, plans are not required to automatically provide, as part of a notice of an adverse benefit determination or otherwise, the identity of experts consulted during the claim determination process. Nor are plans required to disclose the name of experts in the absence of an adverse benefit determination. On the other hand, consistent with the procedural requirements of the regulation, the plan must provide the identity of any such

experts when requested by a claimant in connection with an adverse benefit determination. See § 2560.503-1(h)(3)(iv) and (4).

D-10: Upon receipt of a request from a claimant for the identity of experts consulted by the plan in connection with an adverse benefit determination, may a plan satisfy the requirements of the regulation by providing only the name of the company employing the expert or the qualifications of the expert, rather than the name of the expert?

No. The regulation expressly requires that plans provide for the identification of the medical or vocational expert or experts whose advice was obtained on behalf of the plan in connection with the claimant's claim. Consequently, merely providing the name of the company employing the expert or the qualifications of the expert would not, in the department's view, satisfy this requirement of the regulation. See § 2560.503-1(h)(3)(iv) and (4). See question D-7.

D-11: Does the regulation require that a group health plan provide a claimant with copies of the claimant's medical records relating to his or her benefit claim?

Yes. The regulation requires a plan to provide claimants, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to a claimant's claim for benefits. Under the regulation, relevant documents include, among other things, documents or records relied upon in making a

benefit determination and documents and records submitted in the course of making the benefit determination. Inasmuch as a claimant's medical records relating to the benefit claim would be relevant documents, access to, and copies of, the claimant's medical records would have to be provided upon the claimant's request. The department notes, however, that if a plan has reason to believe that a claimant's medical records contain information that should be explained or disclosed by the physician (or other health professional) who developed the information, it would not be inconsistent with the regulation to refer the claimant to the physician (or other health professional) for such information prior to providing the requested documents directly to the claimant. However, if the physician to whom the claimant was referred failed to provide the requested information to the claimant in a reasonable period of time and without charge, the plan itself would be required to honor the claimant's request.

D-12: Does the regulation require that a plan provide claimants with access to or copies of files of other claimants?

No. The regulation requires that a claimant, have access to, and copies of, documents, records and other information relevant to the claimant's claim. For this purpose, the regulation defines as relevant any document, record, or other information that: (i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon; (iii) demonstrates compliance with the plan's administrative processes and safeguards for ensuring consistent decision

making; or (iv) constitutes a statement of policy or guidance with respect to the group health plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether it was relied upon in making the benefit determination. See §§ 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8).

While information and data from various claimants' files may have been compiled for purposes of developing a plan's criteria, standards, guidelines, or policies to be used in ensuring and demonstrating compliance with administrative processes and safeguards relating to consistent decision making, (see question B-5); or evaluating or assessing treatment options for benefit determinations, only the criteria, standards, guidelines, or policies themselves would have to be disclosed as information relevant to an individual claimant's claim, not the various claimants' files on which such criteria, standards, guidelines, or policies were based.

D-13: Must a plan include, in every notice of adverse benefit determination on review, a statement apprising claimants that – You or your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. department of Labor Office and your state insurance regulatory agency?

The regulation, at § 2560.503-1(j)(5)(iii), provides for the inclusion of the statement described above in all notices of adverse benefit determination on review involving group health and disability claims. However, the department

recognizes that information on the specific voluntary appeal procedures offered by the plan will be provided, consistent with § 2560.503-1(j)(4), in the notice of adverse benefit determination, along with a statement of the claimant's right to bring a civil action under section 502(a) of ERISA. Pending further review, therefore, the department will not seek to enforce compliance with the requirements of § 2560.503-1(j)(5)(iii).

E-1: Under what circumstances may a plan afford claimants the ability to appeal their benefit claim beyond the review level required by the regulation?

While the regulation limits a plan's claims procedure to a maximum of two mandatory appeal levels, the regulation does permit plans to offer voluntary additional levels of appeal, including arbitration or any other form of alternative dispute resolution, provided that certain conditions are met. The conditions of the regulation focus on ensuring that the claimant elects the additional appeal voluntarily. Specifically, the regulation provides that, in the case of such voluntary levels of appeal, the plan's claims procedure must provide:

> The plan will not assert a failure to exhaust administrative remedies where a claimant elects to pursue a claim in court rather than through the voluntary level of appeal
>
> The plan agrees that any statute of limitations applicable to pursuing the claimant's claim in court will be tolled during the period of the voluntary appeal process

The voluntary level of appeal is available only after the claimant has pursued the appeal(s) required by the regulation

The plan provides the claimant with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including the specific information delineated in the regulation

No fees or costs are imposed on the claimant as part of the voluntary appeal process. See § 2560.503-1(c)(3)

E-2: Can a plan's voluntary level of appeal include binding arbitration as a form of benefit dispute resolution?

Yes. Provided that a plan's claims procedure otherwise complies with the conditions of the regulation applicable to voluntary levels of appeal, there is nothing in the regulation that would preclude a plan from using binding arbitration or any other method of dispute resolution. See § 2560.503-1(c)(3). Also see 65 FR at 70253.

E-3: Do the regulation's special rules on voluntary additional levels of appeal, including arbitration, apply to pension plans or welfare plans other than group health plans or plans providing disability benefits?

No. The special rules on post-appeal level reviews apply, under the regulation, only to group health plans and plans that provide disability benefits. All other ERISA-covered

plans are not required by the regulation to comply with these rules. However, if such other plans elect to establish voluntary additional levels of review, those levels would have to comport with the general requirements for a reasonable procedure described in § 2560.503-1(b).

F-1: What are the effective date and applicability dates of the new claims procedure rules?

The regulation became effective as of January 20, 2001. The effective date is the date the regulations became legally effective as part of the Code of Federal Regulations.

The applicability dates are the dates on which plans must begin to comply with the regulation. The applicability date for claims other than group health claims is January 1, 2002. This means that such plans must comply with the regulation beginning with new claims filed on or after January 1, 2002.

As amended on July 9, 2001, the regulation contains separate applicability dates for group health claims and all other claims. Under the regulation as amended on July 9, 2001, the applicability date for group health claims is the first day of the first plan year that begins on or after July 1, 2002, but not later than January 1, 2003. This means that group health plans must comply with the regulation beginning with new claims filed on or after the first day of the first plan year beginning on or after July 1, 2002, but not later than January 1, 2003. For all calendar year group health plans, the applicability date will be January 1, 2003.

Claims that were filed under a plan before the relevant applicability date, and that have not yet been resolved as of the applicability date, may be handled in accordance with the plan's old benefit claims procedures, or, if the plan so chooses, in accordance with the new procedures.

F-2: What principles are likely to be applied when a claimant elects to abandon the plan's administrative claims process in favor of pursuing his or her benefit claim in court?

Section 503 of ERISA requires plans to set up procedures to provide a full and fair review of denied benefit claims. With limited exceptions, claimants must exhaust those internal procedures before filing a civil action for benefits under section 502(a)(1)(B). This requirement reflects a legal presumption favoring exhaustion of internal procedures.

Paragraph (l) of § 2560.503-1 provides that where a plan fails to establish or follow claims procedures consistent with the requirements of the regulation, a claimant shall be deemed to have exhausted the administrative remedies available under the plan. The claimant shall be entitled to pursue any available remedies under section 502(a) on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits.

However, the regulation does not undermine the principle that claimants bear the burden of proving to the satisfaction of the court that the plan failed to establish or follow claims procedures consistent with the requirements of the regulation. In addition, many of the requirements in the regulation give a plan significant discretion in establishing

and following reasonable procedures. For example, paragraph (b)(3) of the regulation prohibits a plan from establishing or administering its procedures so as to unduly inhibit or hamper the initiation or processing of claims for benefits. Accordingly, a plan will be accorded significant deference in evaluating whether it failed to follow a procedure consistent with those aspects of the regulation.

Moreover, not every deviation by a plan from the requirements of the regulation justifies proceeding directly to court. A plan that establishes procedures in full conformity with the regulation might, in processing a particular claim, inadvertently deviate from its procedures. If the plan's procedures provide an opportunity to effectively remedy the inadvertent deviation without prejudice to the claimant, through the internal appeal process or otherwise, then there ordinarily will not have been a failure to establish or follow reasonable procedures as contemplated by § 2560.503-1(l). Thus, for example, a plan that issues a notice of adverse benefit determination fully advising the claimant of the right to review and to request additional information from the plan may be able to correct an inadvertent failure to include in the notice the specific plan provision on which the denial was based. Ordinarily in that circumstance the plan will have provided access to a reasonable claims procedure consistent with the regulations. On the other hand, systematic deviations from the plan procedures, or deviations not susceptible to meaningful correction through plan procedures, such as the failure to include a description of the plan's review procedures in a notice of an adverse benefit determination, would justify a court determination that the plan failed to provide a reasonable procedure.

In addition, filing a lawsuit without exhausting plan procedures could limit claimants' appeal rights and cause claimants to lose benefits to which they otherwise might be entitled. This could be the case when, during the time it takes for a court to dismiss the claimant's suit, the plan's deadline for filing an appeal expires. In this regard, there is nothing in the regulation that would serve to toll internal plan deadlines for filing or appealing claims when suit is brought under section 502(a)(1)(B).

MetLife

September 15, 1998

5950 Airport Road
PO Box 6146
Utica, New York 13504

Law Offices of
Lawrence D. Rohlfing
12631 East Imperial
Highway, Suite C-115
Santa Fe Springs, CA
90670

RE: Long Term Disability
Claim No: 679801078347
Group No: 36663
SS No: 502-58-1030
Claimant: Kenneth Nord

Dear Mr. Rohlfing

This will supplement our August 7, 1998 correspondence.

To date, we have not received the information we requested in our August 7, 1998 letter. Please be advised we will hold Mr. Nord's claim open an additional 30 days awaiting this information. At that time, his claim will be reviewed based on the information in our possession. You will then be notified of our decision.

Yours Truly,

/s/ Kim Ferguson
Kim Ferguson
Senior Case Management Specialist
Met DisAbility
(800) 300-4296

MetLife

5950 Airport Road
PO Box 6146
Utica, New York 13504

August 7, 1998

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Lawrence D. Rohlfing
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Highway, Suite C-115
Santa Fe Springs, CA
90670

RE: Long Term Disability
Claim No: 679801078347
Group No: 36663
SS No: 502-58-1030
Claimant: Kenneth Nord

Dear Mr. Rohlfing

We are writing in reference to Mr. Nord's Long Term Disability that is currently under review.

We are continuing to review this claim and find that we need an additional 60 days to complete the review under the Employee Retirement Income Security Act of 1974 (ERISA).

As you know, that as part of our review process, Mr. Nord attended a independent medical examination on July 17, 1998. We have enclosed a copy for your review.

It is our impression based upon the report that the Mr. Nord could return to his own sedentary occupation as he does not have physical restrictions that should prevent this.

In order to provide Mr. Nord with a full and fair review, we are requesting you provide his attending physician with a copy of this report. We ask that if the doctor disagrees with our assessment, to please explain by providing or referencing specific clinical/objective medical evidence

that will help support his position and limitations that the Mr. Nord is totally disabled and unable to perform his occupation. If the doctor is in agreement with our assessment, please have him sign and date this notice for our record.

Your time, consideration and continued patience in this matter is greatly appreciated. If you have any questions or concerns with regard to this matter, please do not hesitate to contact our office.

Sincerely,

/s/ Kim Ferguson
Kim Ferguson
Senior Case Management Specialist
Met DisAbility
(800) 300-4296

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Attorneys for Defendant
The Black & Decker Disability Plan

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

Kenneth L. Nord Plaintiff, vs. The Black & Decker Disability Plan Defendant.	Case No. CV 99-0408 CM (CTx) **DECLARATION OF RAYMOND J. BRUSCA** Date: February 28, 2000 Time: 9:00 a.m.

I, Raymond J. Brusca, declare as follows:

1. I am the Vice President of Benefits for The Black & Decker Corporation and I am designated as the Plan Manager for The Black & Decker Disability Plan (the "Plan.") I have personal knowledge of the facts set forth below and if called as a witness, I could and would testify competently thereto.

2. Kenneth Nord is a former employee of Kwikset Corporation, a wholly-owned subsidiary of The Black & Decker Corporation.

3. As a Material Planner at Kwikset, Mr. Nord controlled inventory levels, ordered goods and interacted with vendors.

4. Kwikset employees are eligible to participate in The Black & Decker Disability Plan, which is administered and funded by Black & Decker entities.

5. On or about July 15, 1997, Mr. Nord ceased working due to a back injury and submitted a claim for long term disability benefits under the Plan.

6. A true and correct copy of the Summary Plan Description pertaining to the Plan that was in effect in 1997 is attached hereto as Exhibit A.

7. A true and correct copy of the Plan Document that was in effect in 1997 is attached hereto as Exhibit B.

8. Attached hereto as Exhibit C is a true and correct copy of the Benefits file pertaining to Kenneth Nord, as of October 27, 1998.

9. The file contains all of the information that was given to my office from Metropolitan Life Insurance Company ("MetLife"), located in Utica, New York.

10. During the time period that is relevant to this action, the Plan Manager delegated claims administration to MetLife, as permitted by the Plan.

11. (a) At that time, MetLife was required to make an initial determination of eligibility for benefits and communicate that conclusion to the claimant, with information on how to submit additional information and seek review of that decision with MetLife's Group Claims Review.

(b) When requested by the claimant, MetLife conducted a review of that decision, and communicated the results to my office.

(c) My office considered MetLife's recommendation and the information in the file at that time. If we agreed with that recommendation, we communicated the results of that internal MetLife review to the claimant, with a notice of his appeal rights under ERISA.

12. This is the process that occurred with respect to Mr. Nord's claim.

13. MetLife initially denied Mr. Nord's claim on February 16, 1998. Its letter to Mr. Nord informed him of the process by which he could have MetLife informally review that determination.

14. Mr. Nord requested a review with MetLife's Group Claims Review.

15. MetLife sent me a letter dated October 15, 1998, in which it explained that its conclusion was that Mr. Nord's claim was properly denied. The letter enclosed "all of the information considered."

16. On October 21, 1998, MetLife sent me another letter, enclosing an October 14, 1998 letter from Mr. Nord's attorney and a "Work Capacity Evaluation" form that had been completed by Kwikset's Human Resources' Representative, Janmarie Forward. MetLife's letter stated that its decision was unchanged, even considering this latest information.

17. Upon receiving the second letter and the Work Capacity Evaluation, I telephoned Janmarie Forward to discuss the document with her. We discussed the specific

duties that were required of Mr. Nord in his position as a Material Planner and his freedom of movement in that position, which was essentially a desk job. He was able to sit or stand at will, and should he have needed any help lifting any items, help was available for him.

18. The Work Capacity Evaluation made no reference to Mr. Nord's tolerance of the pain or ability to do his job with medication.

19. After reviewing the documentation forwarded to me by MetLife and after my conversation with Ms. Forward concerning her responses in the Work Capacity Evaluation and Mr. Nord's particular job responsibilities, I concluded that MetLife's conclusion that benefits were properly denied was correct: Mr. Nord had not shown his "complete inability" to "engage in his regular occupation," as disability is defined by the Plan.

20. Consequently, I directed Jacquelene Redmond to send a letter dated October 27, 1998 to Mr. Nord, confirming the denial of his claim and informing him of his rights to appeal under ERISA. A true and correct copy of that letter is attached hereto as Exhibit D.

21. Mr. Nord did not appeal as outlined in the October 27, 1998 letter.

22. Had Mr. Nord appealed as explained in that letter, the denial would have received a review by the Claims Appeal Committee in Towson, Maryland. At that time, the Claims Appeal Committee consisted of myself and five other persons.

23. On February 24, 1998, I informed Kwikset's Human Resources Director, Loren Meigide, that Mr. Nord's claim for long term disability benefits had been

denied by MetLife. A true and correct copy of this e-mail to Mr. Meigide is attached hereto as Exhibit E.

24. Under Kwikset's policy, when an employee is no longer on an approved leave, he or she must either return to work or be terminated. I sent this notice to Kwikset as a matter of routine practice.

25. MetLife had no role whatsoever in employment decisions, and never advised myself or the Company to terminate anyone's employment, including Mr. Nord's.

26. The e-mails attached hereto as Exhibit F are intercompany e-mails among personnel at Kwikset and/or Black & Decker. None of these communications are communications to or from MetLife.

27. The Plan provides for the calculation of benefits at Sections 2.02 and at Article VI and Article VII. The monthly long term disability benefit is based on the claimant's regular earnings immediately preceding the period of disability and is integrated with social security benefits and any disability benefits provided by state or federal law.

28. Had Mr. Nord's claim been granted, the calculation of his monthly benefit is as follows:

Annual Base Salary ($41,496) X LTD Rate (70%) ÷ 12 = Gross Monthly Benefit ($2,420.60).

The Plan offsets the gross monthly benefit by the estimated monthly entitlement to Social Security benefits (under Section 7.02(A)(1)), which is $1238 per month, leaving a net monthly benefit of $1,182.60. Mr. Nord was paid six months of Salary Continuance, which commenced when he went out on leave in July 1997. His monthly

benefit for his seventh through thirtieth month of disability would have been $1,182 per month, pursuant to Section 6.03(B). In addition, if Plaintiff received state disability benefits from the state of California, that amount must be offset as well, pursuant to Section 7.02(A)(4).

29. Beginning with the 31st month of disability, the Plan provides a new definition of disability: under Section 6.01, benefits continue only for claimants who are disabled from any gainful occupation for which they are reasonably qualified.

30. In addition benefits cease after 30 months for any disability that it attributable to neuromusculoskeletal or soft tissue disorders, under Section 6.04(H) of the Plan.

31. Because Mr. Nord's claim was denied under the "own occupation" definition of disability, the Plan never reached the issues that come into consideration after the 30th month of disability.

I declare under penalty of perjury of the United States of America that the forgoing is true and correct and that this declaration was executed on February 4th, 2000, at Towson, Maryland.

/s/ Raymond J. Brusca
Raymond J. Brusca

[Exhibits Are Bound Separately As A Lodging]

Supreme Court, U.S.
FILED
NOV 22 2002

No. 02-469

In The

Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

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I

STATEMENT OF THE CASE

This case arises under the Employee Retirement Income Security Act of 1974, as amended (ERISA) for the receipt of disability welfare plan benefits. Respondent Kenneth Nord filed the instant action on January 14, 1999, in the United States District Court for the Central District of California, seeking those benefits and a declaration of his rights to receive disability welfare plan benefits from the Black & Decker Disability Plan. The district court entered judgment in favor of the Disability Plan and against Kenneth Nord. *Petitioner's Appendix* (hereinafter *Pet. App.*) at 18-36. The Ninth Circuit reversed the district court and ordered the payment of benefits during the first 30 months of disability previously denied by the Disability Plan. *Pet. App.* at 15-16.

The Ninth Circuit reasoned that the standard of review of the ultimate decision of the Disability Plan was controlled by the decision in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), *cert. pending* docket no. 01-1840. *Pet. App.* at 10-11. The court of appeal concluded that evidence of rejection of the treating physician opinions coupled with procedural irregularities provided "some evidence of a conflict" of interest relevant to the standard of review. *Pet. App.* at 11. Based on the presence of a conflict of interest, the court of appeal invoked a *de novo* review of the matter as a whole and ordered the payment of benefits. *Pet. App.* at 15-16.

II

SUMMARY OF THE ARGUMENT AND REASONS FOR DENYING THE WRIT

Petitioner presents one question. The petitioner asks whether the treating physician rule found in the body of law surrounding Social Security cases decided by the circuit courts, and contained within the substantial evidence rule in every legal framework where the courts review the decisions of a professional fact finder (a non-jury), applies to disability determinations under ERISA.[1] (*Petition for Writ of Certiorari* at *i* (hereinafter *Pet.*). Petitioner argues that the Ninth Circuit's opinion conflicts with the other circuit courts of appeals, creates confusion

[1] This Court and the Circuit Courts have uniformly utilized the treating physician rule in litigation brought before the federal judiciary. *See*, *Olmstead v. L.C.*, 527 U.S. 581, 610 (1999) (recognizing, within the context of the Americans with Disability Act (ADA), that the opinion of a responsible treating physician ought to be given the greatest of deference); and *Viteck v. Finch*, 438 F.2d 1157, 1160 (4th Cir. 1971) (utilizing the rule in cases arising under the Social Security Act); and *National Mining Assn. v. Dept. of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (utilizing the treating physician rule in cases arising under a claim for benefits under the Black Lung Act); and *Harris v. Railroad Retirement Bd.*, 948 F.2d 123, 126 (2nd Cir. 1991) (utilizing the treating physician rule in cases arising under the Railroad Retirement Act); and *Hensley v. Washington Metropolitan Area Transit Authority*, 655 F.2d 264, 273 fn. 13 (D.C. Cir. 1981) (utilizing the treating physician rule in the federal workers compensation setting); and *Curtis v. Shivers*, 674 F.Supp. 1237, 1240 (E.D. La. 1987) (utilizing the treating physician rule in cases arising under the Federal Tort Claims Act). *Cf. White v. Principi*, 243 F.3d 1378, 1380-1381 (Fed. Cir. 2001) (declining to utilize the treating physician rule in veterans' benefits cases, where Congress and the Veterans Administration specifically prescribed a statutory and regulatory framework for the consideration of evidence and where the treating physician would be employed by the fact-finding agency thereby putting the claimant at a disadvantage).

among the district courts, and creates disparate standards for determination of claims. (*Pet.* at *i* and 8-13).

As read by the petitioner, the Ninth Circuit's holding conflicts with the Second, Third, Fourth, Fifth, Seventh, and Eleventh Circuit Courts of Appeals. (*Pet.* at 15-18). The petitioner concedes that the decision of the Ninth Circuit stands consistent with the jurisprudence of the Eight Circuit. (*Pet.* at 18-20). Petitioner attempts to conflate a conflict where none exists. The Ninth Circuit's opinion is consistent with decisions from the other circuit courts of appeals regarding the treating physician rule's applicability to ERISA disability cases. Even giving petitioner's argument the most liberal of readings, any apparition that is perceived as conflict amongst the circuit courts of appeals is readily distinguished as superficial on the unique facts addressed in each cited case.

Petitioner argues that the application of the treating physician rule somehow strips the plan administrator of the flexibility written into the ERISA regulations. (*Pet.* at ___). The application of the treating physician rule in practice operates differently. The application of the treating physician rule, and the deference shown to treating physicians, merely sharpens the decision-making process by the ERISA plan fiduciary and ultimately the courts, a worthwhile goal.

Petitioner criticizes the Ninth Circuit for believing that plan administrators have an inherent tendency to cheat plan participants and for recognizing that treating physicians are due some deference as a result of the treating relationship. (*Pet.* at 10-11). Petitioner's aspersion is unwarranted. The Ninth Circuit's recognition of the

inherent credibility of a treating physician, absent evidence of actual impropriety, is consistent with this Court's acknowledgment of that concept. *See Olmstead v. L.C.*, 527 U.S. 581, 610 (1999) (Kennedy, J., concurring in the judgment) (opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference)

Petitioner contends that a treating physician's opportunity to bill for more services creates an inherent conflict of interest or possesses a treating physician to render a biased opinion. (*Pet.* at 11-12). Petitioner's implication that a treating physician cannot offer an unbiased professional assessment of a patient's medical condition or operates a medical practice with the intent to commit fraud and issue an unsubstantiated opinion in favor of a claimant is unreasonable and an implication rejected by this court. *See Pegram v. Herdrich*, 530 U.S. 211, 218 (2000) (recognizing that the check on the incentive to provide more care then necessary is a physician's obligation to exercise reasonable medical skill and judgment in the patient's interest). Therefore, this Court itself rejects petitioner's implication that the medical profession is one whose members would risk their licenses to practice medicine by fraudulently certifying disability.

Petitioner contends the concept that treating physicians are entitled to deference imposes a draconian rule. (*Pet.* at 12). Rather than imposing an automatic, controlling, or absolute result, the treating physician rule merely articulates what is commonsense. Namely, that treating doctors have a greater opportunity to know and observe a patient and therefore their opinions should not be dismissed out of hand, but instead given deference. *See Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600

(9th Cir. 1999). The existence of other evidence supporting or detracting from the treating physician's opinions animates the analysis of whether a plan administrator is privileged to reject that opinion as a mixed question of fact and law.

Petitioner attacks the Ninth Circuit's reasoning as "limp" and self-serving. (*Pet.* at 12-13). Petitioner's denigration of the Ninth Circuit, that it merely intends to lighten the, judicial workload within that circuit, ignores the concerns of the federal courts and their limited resources. The circuit courts recognize that the motivating concern of the federal courts in ERISA disability matters is that parties resolve their dispute at the administrator's level. *See Vega v. National Life Insurance Services, Inc.*, 188 F.3d 287, 300 (5th Cir. 1999). That concept is consistent with the goal of a statute, "the purpose of which is at least in part 'to promote the interests of employees and their beneficiaries.'" *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1141 (9th Cir. 2001) *cert. pending* docket no. 01-1840; *quoting Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983). Clarity of result that an unreasonably rejected treating physician's opinion will expose an ERISA plan to benefits and the costs of litigation should act as a deterrent to the whimsical rejection of the treating physician's opinions in the first instance.

Petitioner urges that its petition be granted on the basis that the application of the treating physician rule takes away plan discretion. (*Pet.* at 13). No discretion has been lost. The discretion of an ERISA fiduciary is no different than the discretion of the Commissioner of the Social Security Administration to make any reasonable decision so long as it is supported by substantial evidence. 42 U.S.C. § 405(g). Certainly an ERISA fiduciary that

makes a decision without the support of substantial evidence acts out of an abuse of discretion.

The Ninth Circuit's decision stands congruent with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989), or this Court's most recent interpretation of *Firestone*. *See Rush Prudential HMO v. Moran*, ___ U.S. ___, 122 S.Ct. 2151, ___ fn. 15 (2002). The Ninth Circuit scrupulously applied the same analysis, as this Court did in *Firestone*, in deciding this matter, recognizing that Congress empowered the courts to develop, in the light of reason and experience, a body of federal common law governing employee benefit plans. *See, Menhorn v. Firestone Tire Rubber Co.*, 738 F.2d 1496, 1499 (9th Cir. 1984); *see also, Rush Prudential HMO, Inc. v. Moran, citing Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). Contrary to petitioner's claim, the adoption of the treating physician rule provides for common sense uniformity in the treatment of medical opinions and is consistent with the true primary goal of ERISA, which is to protect employee benefits.

III

ARGUMENT

A

NO CONFLICT EXISTS AMONG THE CIRCUIT COURTS OF APPEALS

Petitioner asserts that the Ninth Circuit's decision facially conflicts with the decisions in six other circuit courts of appeals, and thus provides a basis for the court to grant its petition for a writ of certiorari with respect to the

application of the treating physician rule to ERISA disability claims. (*Pet.* at 14-22). Petitioner misstates the law. The court of appeals painstakingly set out the bases and rationale for application of the treating physician rule in the ERISA disability context. *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001) *cert. pending* docket no. 01-1840. The application of the treating physician rule in the Ninth Circuit is consistent with the decisions of the other circuit courts of appeals.

The Second Circuit Court Of Appeals

The Second Circuit Court of Appeals issued a decision on November 19, 2001, recognizing the treating physician rule in cases arising under ERISA. *See, Conners v. Connecticut Gen. Life Ins. Co.*, 272 F.3d 127 (2nd Cir. 2001). In *Conners*, the court of appeals found error in the district court's failure to recognize that the treating physician had the status of a treating physician, that if the district court had properly so recognized, it would have no doubt accorded that opinion greater weight. *Conners*, 272 F.3d at 135-136. The weight accorded a treating physician under the treating physician rule represents nothing more than a starting point for commonsense analysis of whether the plan's final decision is legally sufficient.

The court of appeals did not adopt the treating physician rule for purposes of the *de novo* standard of review. *Id.*, at 136 fn. 4. The court of appeals in *Conners* explained that the treating physician rule is designed to "encourage the development of the administrative record so that the district court can determine whether the administrator's decision was supported by substantial evidence." *Id.* Therefore, the treating physician rule serves no particular

purpose in the context of *de novo* review by the district court. *Id.* By implication, the Second Circuit applies the treating physician rule to cases before it under the abuse of discretion standard of review, and in practice remanded the matter where the district court violated the common-sense starting point of the treating physician rule under the *de novo* standard. The Second Circuit is consistent with the Ninth Circuit.

The Third Circuit Court of Appeals

The Third Circuit Court of Appeals in *Skretvedt v. E.I. Dupont De Nemours And Co.*, 268 F.3d 167 (3rd Cir. 2001) applied the treating physician rule, citing the Ninth Circuit's decision in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001) *cert. pending* docket no. 01-1840. *Skretvedt v. E.I. Dupont*, 268 F.3d at 184. In *Skretvedt*, the court of appeals analyzed an application for disability benefits under ERISA and the abuse of discretion standard. The court of appeals summarily concluded without fanfare that:

> We have long recognized that in the analogous area of disability benefits determinations under the Social Security Act, the "opinions of a claimant's treating physician[s] are entitled to substantial and at times even controlling weight." *Fargnoli v. Massanari*, 247 F.3d 34, 43 (3d Cir. 2001); *see also Cotter v. Harris*, 642 F.2d 700, 704 (3d Cir. 1981); *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001).

Id. Therefore, the Third Circuit agrees with the Ninth Circuit's decision in the present matter.

Petitioner did not rely on the Third Circuit decision in *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 43 (3rd Cir. 1993). In *Abnathya*, the Third Circuit did not reject the treating physician rule; it utilized it. *Abnathya* rejected the conclusory note of the treating physician in favor of the more detailed opinion of the examining physicians. *Abnathya*, 2 F.3d at 43. That is precisely how the treating physician rule is applied in practice. (*See, Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001) (explaining that the deference given to the treating opinion under the rule is not absolute and subject to rejection based on the articulation of sufficient reasons supported by substantial evidence within the record)).

Therefore, the Third Circuit in *Abnathya* applied a corollary doctrine of the treating physician rule, that conclusory opinions are not entitled to deference. The court of appeal simply applied the name to the doctrine in *Skretvedt*. The Third Circuit's decisions do not, as petitioner alleges, deepen the split among the circuit courts of appeals. (*Pet.* at 22). Rather, the Third Circuit has incrementally and iteratively adopted the treating physician rule. *See, Skretvedt*, 268 F.3d at 184; *see also Edgerton v. CNA Ins., Co.*, 215 F.Supp. 2d 541, 549 (E.D. Pa. 2002) (applying *Skretvedt* and *Regula*, holding that the rationale of the treating physician rule equally applies to the area of determining whether an individual is disabled for the purposes of an ERISA plan, where a plan administrator, like the Social Security Administration, must look at the claims file to determine whether an individual qualifies for disability benefits).

The Fourth Circuit Court Of Appeals

Petitioner relies upon the Fourth Circuit's decision in *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 608 (4th Cir. 1999), to find a conflict. (*Pet.* at 17). A fair reading of *Elliott* does not repudiate the treating physician rule. In *Elliott* the application of the treating physician rule to the facts of that case made no difference in light of the "persuasive contradictory evidence." *Id., citing Foster v. Heckler*, 780 F.2d 1125, 1130 (4th Cir. 1986) (finding that substantial contrary evidence existed to overcome any deference afforded a treating physician). The Fourth Circuit has clearly used the parameters of the treating physician rule to determine at least in the alternative that the rule's application had no basis in fact to the case presented to it. *Elliott*, 190 F.3d at 608.

Elliott ignored the prior learned dictum in *Sheppard & Enoch Pratt Hospital, Inc. v. Travelers Insurance Company*, 32 F.3d 120, 126 (4th Cir. 1994). In the context of the doctor trying to obtain plan benefits, Sheppard declined to adopt the treating physician rule. *Sheppard & Enoch Pratt Hospital*, 32 F.3d at 126. In *Sheppard* the treating physician had an obvious and material conflict, i.e., the payment of benefits directly to the doctors or medical care facility. *Id.* The court of appeals noted that the treating physician rule is appropriate when the application of that rule involves an assessment of whether the claimant is in fact disabled. *Id.* The Ninth Circuit dealt with the same issue finding that where evidence of "actual improprieties" exists, the fact finder is privileged to reject the opinions of the treating physician without further ado. *Saelee v. Chater*, 94 F.3d 520, 523 (9th Cir. 1996).

The petitioner relies on *Webster v. Black & Decker (U.S.), Inc.*, 33 Fed. Appx. 69, 75, 2002 WL 533653, *5 (4th Cir. April 10, 2002) (unpublished) for the propositions that the treating physician rule does not apply and that it can resolve conflicting medical evidence. (*Pet.* at 17, fn. 4). However, the court of appeal in *Webster* affirmed because the medical and vocational information relied upon was more detailed than the treating physician opinions. *Id.*

This is consistent with the full understanding of the treating physician rule, i.e., that the administrator can reject those opinions where contradicted by substantial evidence. The utilization of the treating physician rule in *Webster* explicitly refutes petitioner's argument that the rule strips plan administrators of adjudicatory discretion. The treating physician rule as applied in *Webster* demonstrates that the rule merely sharpens the decision-making process by a plan administrator, a worthwhile goal.

As the Ninth Circuit recognized in the present matter, the facts of *Sheppard* and the application of the treating physician rule are distinguishable when the issue is whether that rule applies in disputes over prescribed treatment, i.e., disputes over the payment of health care benefits directly to a physician rather then the receipt of disability benefits by the claimant. *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1143 (9th Cir. 2001). The Ninth Circuit and the Fourth Circuit are complimentary. At most, there is an intra-circuit tension in the Fourth Circuit about the application of the treating physician rule to ERISA disability matters, between *Sheppard's* dictum and *Elliott's* observation that the rule would not change the outcome in that case.

The Fifth Circuit Court of Appeals

The petitioner relies upon the Fifth Circuit's decisions in *Salley v. E. I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) but not *Dowden v. Blue Cross & Blue Shield of Texas, Inc.*, 126 F.3d 641, 644 (5th Cir. 1997). (*Pet.* at 17-18). The court of appeals held that application of the treating physician rule to the distinct facts of the cases was not appropriate.

The court of appeals in both cases declined to adopt the treating physician rule in the context of the doctor trying to obtain plan benefits. *Dowden*, 126 F.3d at 644 and *Salley*, 966 F.2d at 1016. In *Dowden* and *Salley,* the facts indicate that the treating physicians had an obvious and material conflict, i.e., the payment of benefits directly to the doctors or medical care facility. *Id*. The Fifth Circuit stated that where such a conflict exists, the treating physician rule does not apply. *Salley* at 1016. The Ninth Circuit dealt with the same issue, finding that where evidence of "actual improprieties" exists, the fact finder is privileged to reject the opinions of the treating physician without further ado. *Saelee v. Chater*, 94 F.3d at 523.

But as the Ninth Circuit recognized in the present matter, the facts of *Dowden* and *Salley* and the application of the treating physician rule are distinguishable when the issue is whether that rule applies in disputes over prescribed treatment, i.e., disputes over the payment of health care benefits directly to a physician rather then the receipt of disability benefits by the claimant. No conflict exists between the Ninth and Fifth Circuits on this issue, i.e., whether the treating physician rule applies in disability cases.

The Sixth Circuit Court of Appeals

Jackson v. Metropolitan Life, 24 Fed. Appx. 290, 293, 2001 WL 1450811, *2-3 (6th Cir. Oct. 29, 2001) (unpublished), for whatever minimal weight an unpublished opinion may carry, does not stand for a different proposition. There, the court of appeal relied on *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834 (8th Cir. 2001) (*Marshall*) for the notion that the treating physician rule does not apply. *Id.* However, the court stated that applying the treating physician rule would not change the result because of the substantial evidence contradicting the treating physician opinions.

The Seventh Circuit Court of Appeals

The petitioner cites *Wilczynski v. Kemper Nat'l Ins. Co.*, 178 F.3d 933, 938 (7th Cir. 1999) to support the thought that treating physicians are not entitled to special weight. However, the court relied on the opinions of treating physicians in a conflicted record to affirm the decision of the carrier. *Id.* Resolving conflicts between treating physicians stands consistent with the treating physician rule or the grant of deference to those opinions.

The Eight Circuit Court of Appeals

The petitioner recognizes that *Donaho v. FMC Corp.*, 74 F.3d 894, 899 (8th Cir. 1996) supports the proposition that the treating physician rule applies in the disability context of ERISA matters. (*Pet.* at 19). Petitioner rests considerable weight on the Eighth Circuit's later opinion in *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834 (8th Cir. 2001) (*Marshall*). (*Pet.* at

19). The issues raised with respect to *Marshall* are two-fold.

The first is whether *Marshall* could overturn *Donaho*. It cannot. *U.S. v. Franklin*, 250 F.3d 653, 665 (8th Cir. 2001) ("it is well established, however, that one panel of this court may not overrule another and so we must decline appellant's invitation to reconsider our prior decision").

The second question is whether the Eighth Circuit in *Marshall* expanded or constricted the incorporation of Social Security concepts into the ERISA disability paradigm. Upon careful analysis, the Eighth Circuit expanded its incorporation of Social Security concepts. *Marshall*, 258 F.3d at 843 states:

> As we recently observed, however, a treating physician's opinion does "not automatically control, since the record must be evaluated as a whole." *Fletcher-Merrit* [*v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 n. 3 (8th Cir.2001)] (*citing Bentley v. Shalala*, 52 F.3d 784, 786 (8th Cir.1995)).

The Eighth Circuit clearly adopted the treating physician rule in *Donaho*, 74 F.3d at 899. It is clear upon careful reading of *Marshall* that the Eighth Circuit did not retreat from the pronouncement of the treating physician rule in *Donaho*, but instead continued to import the applicable tools from the Social Security decisional paradigm by citing *Bentley v. Shalala, supra*.

The holding in *Marshall* is consistent with the treating physician rule in its full regalia as understood and applied in the circuits. *See e.g., Reddick v. Chater*, 157 F.3d 715, 720 (9th Cir. 1998) (rejecting the isolation of a quantum of evidence approach). The proposition is patent on

the face of *Marshall* in any event; the court of appeals cited a Social Security case for the proposition that the treating physician rule is tempered by the need to review the record as a whole. *Marshall*, 258 F.3d 843, *citing Bentley v. Shalala*, 52 F.3d at 786. The Eighth Circuit has properly expanded its reliance on Social Security cases to develop the common law of ERISA.

The Eighth Circuit continues in its adoption and refinement of the treating physician rule in *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793, 799 (8th Cir. 2002) (*citing* and *applying Donaho*, giving deference to treating physician, but finding that plan administrators properly rejected the treating opinions); *see also*, *Conley v. Pitney Bowes*, 176 F.3d 1044, 1049 (8th Cir. 1999) (applying and finding that the rule is not that a treating physician opinion trumps all other evidence, but that a court must give it appropriate weight); and *Dodson v. Woodmen of the World Life Ins. Soc.*, 109 F.3d 436, 438 (8th Cir. 1997) (same).

There exists no conflict between the Eight Circuit's decision in *Donaho* and the Ninth Circuit's decision in the present matter or *Regula v. Delta Family-Care Disability Survivorship Plan, supra*. The final informed analysis illustrates that the Eight Circuit continues to incorporate relevant concepts from the common law surrounding the Social Security Act's disability provisions into its ERISA jurisprudence.

The Eleventh Circuit Court Of Appeals

The petitioner relies upon the Eleventh Circuit's decision in *Jett v. Blue Cross and Blue Shield of Alabama*, 890 F.2d 1137, 1139 (11th Cir. 1989) (*Jett*), as evidence of

conflict. (*Pet.* at 18). As the Ninth Circuit stated in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1143 (9th Cir. 2001) *cert. pending* docket no. 01-1840, *Jett* involved medical eligibility for payment claim. *Jett* declined to adopt the treating physician rule in the context of a doctor trying to obtain plan benefits. *Jett*, 890 F.3d at 1138. In *Jett*, the facts indicate that the treating physician had an obvious and material conflict. *Id.* [2] The Eleventh Circuit stated that where such a conflict exists, the treating physician rule does not apply. *Jett*, 890 F.3d at 1138. The Ninth Circuit has dealt with the same issue finding that, where evidence of "actual improprieties" exists in the rubric of the treating physician rule, the fact finder is privileged to reject the opinions of the treating physician without further ado. *Saelee v. Chater*, 94 F.3d at 523. *Jett* does not represent the last word on the matter.

Levinson v. Reliance Standard Life Ins. Co., 245 F.3d 1321 (11th Cir. 2001) (*Levinson*) answers the question within the jurisdictional boundaries of the Eleventh Circuit where no evidence of impropriety exists. The court of appeals noted that the district court had given less weight to the opinion of a reviewing physician and more weight to the treating physician relying upon *Donaho*. *Levinson*, 245 F.3d at 1329. The court of appeals affirmed the decision of the district court including its reliance upon *Donaho* to give greater weight to the opinions of a treating physician. *Levinson*, 245 F.3d at 1332. Judge Cox in partial dissent differed only in the remedy, stating that he

[2] In *Jett*, the claimant and treating physician sought plan benefits and a determination that psychiatric hospitalization was medically necessary, where the treating physician was employed by the hospital.

would remand for further consideration by the carrier of an unaddressed issue. *Levinson*, 245 F.3d at 1332-1333 (J. Cox, concurring in part and dissenting in part). Therefore, the entire panel agreed with the weight of the evidence assigned by the district court and its reliance upon *Donaho*. The Eleventh Circuit has thus affirmed the use of the treating physician rule in ERISA *disability benefit* cases in *Levinson*, which is distinguishable from its decision in *Jett*, dealing with the issue of the treating physician rule within the context of *health care benefits*.

Petitioner ignores the opinion in *Levinson*, failing to cite or discuss it in its petition. Rather, petitioner relies on the recent Eleventh Circuit decision in *Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002). (*Pet.* 18). The *Turner* decision is not binding precedent. *See, Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc) (a later panel may not overrule an earlier panel decision, following the old Fifth Circuit rule).

The Eleventh Circuit in *Levinson* issued a panel decision, distinguishable on its face from *Jett*, affirming the use of the treating physician rule within the ERISA context where the treating physician does not have an economic interest. That opinion is binding on the Eleventh Circuit. The Eleventh Circuit held in *Godfrey v. Bellsouth Telecommunications, Inc.*, 89 F.3d 755, 758-760 (11th Cir. 1996) that a plan administrator commits an abuse of discretion in ignoring the opinions of the treating physicians and relying on in-house physicians. *Id.* The court concluded that to ignore the treating physician advanced the proposition that the decision was tainted by a palpable conflict of interest. *Id.*

There exists no tension between the Eleventh Circuit's decision in *Jett* and the Ninth Circuit's decision in the present matter. At most, there is an intra-circuit tension in the Eleventh Circuit about the application of the treating physician rule to ERISA disability benefit matters, between the panel decisions in *Godfrey*, *Levinson*, and *Turner*.

Summation

The Ninth Circuit Court of Appeals' decision in the present matter stands consistent with her sister circuit courts. The opinions of the circuit courts that have decided the issue of whether the treating physician rule applies to cases arising under ERISA in determining a claimant's eligibility for *disability benefits* have found that it does. The cases decided under a claim for *health care benefits* are also consistent throughout the circuit courts, finding that where an actual impropriety exists the rule does not apply. Based on this distinction, no conflict exists among the decisions of the circuit courts of appeals. Petitioner has raised the mere apparition of a conflict that, upon close examination, is nothing more than miniscule intra-circuit tension fleshing out the body of the common law concepts.

Justice Kennedy said it best:

> The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.

Olmstead v. L.C., 527 U.S. 581, 610 (1999) (Kennedy, J., concurring in the judgment) (under the Americans with Disability Act).

The Ninth Circuit's incorporation of the treating physician rule is applicable to disability determinations arising under ERISA, is consistent with the Congressional mandate that the federal judiciary is charged with the development of a body of federal common law governing employee benefit plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 *citing* 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits) ([i]t is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans); *see also Menhorn v. Firestone Tire Rubber Co.*, 738 F.2d 1496, 1499 (9th Cir. 1984). The Ninth Circuit's recognition that the "treating physician rule" may be utilized within the context of actions brought under ERISA is nothing more then the recognition, consistent with that of Justice Kennedy's, that treating physicians are entitled to deference.

The court of appeals did not "borrow" the "treating physician rule." As recognized by the Ninth Circuit:

> It has long been settled among the circuit courts that disability determinations under SSA will be guided by the treating physician rule. *See Murray v. Heckler*, 722 F.2d 499, 501 (9th Cir. 1983) (joining the Second, Fifth, and Sixth Circuits in holding that the treating physician's opinions should be accorded greater weight than that of an examining or reviewing physician). The Social Security Administration subsequently codified the treating physician rule in its regulations governing disability determinations. *See* 20 C.F.R. § 404.1527(d), 416.927(d) (2001).

Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130, 1150 (9th Cir. 2001), *cert. pending* docket

no. 01-1840. It is the Social Security Administration that acquiesced to the concept of the treating physician rule from the common law, a rule and concept utilized by federal courts with respect to suits arising under the ADA, Black Lung Act, Railroad Benefits Act, and Federal Tort Claims Act.[3]

The Ninth Circuit's decision does not incorporate the Social Security Act into the ERISA context. The treating physician rule is not an absolute, requiring a plan to give a treating physician controlling authority; it is merely the common sense recognition, as articulated by Justice Kennedy in *Olmstead v. L.C.*, that a treating physician opinion is entitled to deference. *Olmstead v. L.C.*, 527 U.S. at 610. A treating physician is afforded deference because he has a greater opportunity to "know and observe the individual as a whole." (*Pet. App.* at 15a, *quoting Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999). As the court of appeals found, such deference is warranted under a statute, "the purpose of which is at least in part 'to promote the interests of employees and their beneficiaries.'" (*Pet. App.* at 17a *quoting Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983)). Therefore, the "treating physician rule" is properly found within ERISA.

IV

CONCLUSION

There exists no conflict in this case between the Ninth Circuit's decision and the other circuit courts. The Ninth

[3] *See*, cases cited *supra* note 1.

Circuit's application of the treating physician rule is consistent with this Court's and the Circuit Court's utilization of that rule throughout the body of federal law and effectuates the purpose of ERISA. Further, the Ninth Circuit's opinion is consistent with this Court's mandate that the federal judiciary is charged with the development of a body of federal common law. For all the forgoing reasons, Respondents respectfully request that this Honorable Court deny the Petition.

Respectfully submitted,

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No. 02-469

FILED
24
FEB 24 2003
CLERK

In The
Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

JOINT APPENDIX

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General Docket
US Court of Appeals for the Ninth Circuit

4/27/00	DOCKETED CAUSE AND ENTERED APPEARANCES OF COUNSEL. CADS SENT (Y/N): y. Setting schedule as follows: CADS is past due; CADS must be filed no later than 5/4/00 for Lawrence Rohlfing; appellant's designation of RT is due 4/24/00; appellee's designation of RT is due 5/2/00; appellant shall order transcript by 5/12/00; court reporter shall file transcript in DC by 6/12/00; certificate of record shall be filed by 6/19/00; appellant's opening brief is due 7/31/00; appellees' brief is due 8/28/00; appellants' reply brief is due 9/11/00; [00-56689] (rmw)
6/1/00	Filed Lawrence D. Rohlfing for Aplt Civil Appeals Docketing Statement served on 5/30/00 (to CONFATT) [00-55689] [00-55689] (kkw)
6/21/00	Filed order (deputy Clerk: bsp/CONFATT) this case is under consideration for inclusion in the Mediation Program. A settlement assessment conference will be held by telephone on 7/10/00 at 2:00 p.m. PACIFIC (San Francisco) Time. The briefing schedule previously set by the court remains in effect. [00-55689] (jr)
6/26/00	Received copy of transcript designation and ordering form filed in DC (set to case file) (sm)
7/11/00	Filed certificate of record on appeal RT filed in DC 6/23/00 [00-55689] (pg)
7/12/00	Filed order CONFATT (LJE) Case not selected for program. Counsel interested in obtaining settlement assistance or program information should contact mediation office in SF. Counsel are requested to serve copies of this order on

their clients. Briefing schedule set forth in the court's order filed 4/27/00 shall remain in effect. [00-55689] (em)

7/31/00 14 day oral extension by phone of time to file brief. [00-55689] appellants' brief due 8/14/00; appellees' brief due 9/13/00; the optional reply brief is due 14 days . . . (king)

8/16/00 Filed original and 15 copies Appellant Kenneth L. Nord opening brief (Informal: n) 54 pages and five excerpts of record in 1 volume; served on 8/14/00 (note: requested counsel to amend the letter informing aple of new briefing schedule) [00-55689] (em)

8/23/00 Received Lawrence D. Rohlfing for Appellant Kenneth L. Nord letter dated 8/21/00 re: amending letter showing new briefing schedule. CASE FILE [00-55689] (em)

9/12/00 14 day oral extension by phone of time to file Appellee The Black & Decker's brief. [00-55689] appellees' brief due 9/27/00; appellants' reply brief due 14 days . . . (jlc)

9/28/00 Filed original and 15 copies appellee The Black & Decker's 19 pages brief, 1 supp Exc. vol; served on 9/27/00 [00-55689] (em)

10/12/00 14 day oral extension by phone of time to file 's [sic] reply brief. [00-55689] appellants' reply brief due 10/30/00; (king)

11/1/00 Filed original and 15 copies Kenneth L. Nord reply brief, (Informal: n) 21 pages; served on 10/30/00 [00-55689] (gar)

6/22/01 Calendar check performed [00-55689] (aw)

7/17/01 Calendar materials being prepared. [00-55689] [00-55689] (mw)

7/25/01 CALENDARED: Pasadena October 16, 2001 9:00 a.m. Courtroom 3 [00-55689] (mw)

9/18/01 FILED CERTIFIED RECORD ON APPEAL IN 4 VOLS. (TOTAL): 2 CLERKS REC 1 RTs and one dkt #21 (Original) [00-55689] (kym)

10/12/01 Filed order (Betty B. FLETCHER, Dorothy W. NELSON, M. M. MCKEOWN,): The parties should be prepared to discuss Regular v. Delta Family Care Disability Survivors Plan, 98-55853, Slip Op. 1t 13479 filed 9/24/01 at oral argument. (phoned aple, faxed aplt) [00-55689] (em)

10/16/01 ARGUED AND SUBMITTED TO Betty B. FLETCHER, Dorothy W. NELSON, M. M. MCKEOWN. [00-55689] (bg)

12/20/01 Rec'd notice of change of address from Lee T. Paterson and Amanda C. Sommerfeld for appellee The Black & Decker; served on 12/19/01. [00-55689] (hh)

7/15/02 FILED OPINION: REVERSED (Terminated on the Merits after Oral Hearing; Reversed; Written, Signed, Published. Betty B. FLETCHER, author; Dorothy W. NELSON; M. M. McKEOWN.) FILED AND ENTERED JUDGMENT. [00-55689] (em)

7/22/02 Filed Appellant Kenneth L. Nord bill of costs, served on 7/19/02 ($628.80) [00-55689] (em)

7/29/02 Filed Lawrence D. Rohlfing's motion for attorney(s)' fees in the amount of $18,154.00; served on 7/26/02 (to Moatt 8/12/02) (em)

8/6/02	MANDATE ISSUED; COSTS TAXED FOR $628.80 [00-55689] (em)
8/23/02	Filed order MOATT (ME) Aplt's unopposed mtn for aty fees is granted in the amount of $18,154.00. [00-55689] (kkw)
9/30/02	Received notice from Supreme Court: petition for certiorari filed Supreme Court No. 02-469 filed on 9/24/02. [00-55689] (em)
1/31/03	Received notice from Supreme Court, petition for certiorari GRANTED on 1/10/03. Supreme Court No. 02-469 (hh)

U.S. District Court
Central District of California (Western Div.)

1/14/99	1	COMPLAINT filed Summons(es) issued referred to Discovery Carolyn Turchin (jp) [Entry date 01/19/99]
2/3/99	2	Standing ORDER by Judge Carlos R. Moreno (tw) [Entry date 02/08/99]
2/4/99	3	Proof of service of SC executed upon defendant Black & Decker on 2/3/99 svd Charles E Fentz, Sr Vice President & General Cnsl by mail (jc) [Entry date 02/09/99]
2/4/99	3	NOTICE AND ACKNOWLEDGEMENT of receipt of summons and complaint by defendant Black & Decker on 1/21/99 received by Charles E Fentz, Sr Vice President & General Cnsl (jc) [Entry date 02/09/99]
3/22/99	4	ANSWER filed by defendant Black & Decker to complaint [1-1] (tw) [Entry date 03/23/99]
3/23/99	5	MINUTES: The crt is in rcpt of dfts ans. The initials CM stand for Judge Carlos Moreno & not Judge Marshall. Please correct your file since it delays pldgs in getting to the right Judge. by Judge Carlos R. Moreno CR: n/a (tw) [Entry date 03/26/99]
7/23/99	6	MINUTES: osc re dism for lack of prosecution; plf is ord to show cause in writing no later than 8/15/99 why actn sh not be dism. Crt will consider the filing of joint rpt of early meeting as appropriate resp to this osc. by Judge Carlos R. Moreno CR: n/a (tw) [Entry date 07/26/99]

8/30/99	7	ORDER of dism by Judge Carlos R. Moreno. The crt ords that this actn be of hereby is dism w/o prej for lack of prosecution & failure to comply wi ords of the crt. terminating case (MD JS-6). (ENT 9/1/99), mld ntcs. (tw) [Entry date 09/01/99]
9/2/99	8	JOINT REPORT OF EARLY MEETING OF COUNSEL filed. Estimated length of trial 2 days (jag) [Entry date 09/03/99]
9/3/99	9	NOTICE OF MOTION AND MOTION by plaintiff Kenneth L Nord for relief from ord of dismissal & response to OSC; motion hearing set for 9:00 9/27/99; Decl of Lawrence D Rohlfing (jag) [Entry date 09/09/99]
9/27/99	10	ORDER by Judge Carlos R. Moreno vacating order of dism [7-1], [7-2], & discharging OSC Nunc Pro Tunc to 8/15/99. Case Reopened (MD JS-5). (ENT 9/28/99), mld ntcs. (tw) [Entry date 09/28/99]
12/10/99	11	MINUTES:; mandatory status & Sched conference set on 10:00 1/10/00 by Judge Carlos R. Moreno CR: n/a (tw) [Entry date 12/14/99]
1/10/00	12	ATTORNEY SUBSTITUTION: terminating attorney Amanda C Sommerfeld for Black & Decker, attorney Lee T Paterson for Black & Decker by defendant Black & Decker and substituting attorney Lee T Paterson by Judge Carlos R. Moreno (tw) [Entry date 01/12/00]
1/10/00	13	MINUTES: Mandatory status conf; mandatory status conference held; trial set on 9:00 3/28/00. Mot hrg cutoff 2/7/00, 9:00 by

		Judge Carlos R. Moreno CR: Deborah Gackle (tw) [Entry date 01/13/00]
1/18/00	14	NOTICE OF MOTION AND MOTION by plaintiff Kenneth L Nord for summary judgment; motion hearing set for 9:00 2/7/00 Lodged stmt of facts, order (tw) [Entry date 01/20/00]
1/18/00	15	Indexes of clm file by plaintiff Kenneth L Nord (tw) [Entry date 01/20/00]
1/18/00	16	DECLARATION of Freeman Leeth by plaintiff Kenneth L Nord in suppt of motion for summary judgment [14-1] (tw) [Entry date 01/20/00]
1/25/00	17	STIPULATION and ORDER by Judge Carlos R. Moreno to cont hearing on motion for summary judgment [14-1] 9:00 2/28/00 (tw) [Entry date 01/26/00]
2/7/00	18	DECLARATION of Raymond J. Brusca by defendant (ir) [Entry date 02/08/00]
2/7/00	19	NOTICE OF MOTION AND MOTION by defendant Black & Decker for summary judgment, or alt for summary adjudication; motion hearing set for 9:00 2/28/00 Lodged p/o, stmt (tw) [Entry date 02/08/00]
2/7/00	20	MEMORANDUM of PA IN SUPPORT by defendant Black & Decker of motion for summary judgment [19-1], motion for summary adjudication [19-2] (tw) [Entry date 02/08/00]
2/7/00	21	DECLARATION of Lawrence D. Rohlfing by plaintiff Kenneth L Nord in suppt of motion for summary judgment [14-1] (tw) [Entry date 02/08/00]

2/7/00 22 DECLARATION of AMANDA C. SOMMERFELD by defendant Black & Decker (yl) [Entry date 02/08/00]

2/14/00 23 STATEMENT of material facts by plaintiff Kenneth L Nord in opp to dfts motion for summary judgment [19-1], motion for summary adjudication [19-2] (tw) [Entry date 02/16/00]

2/14/00 24 OPPOSITION by plaintiff Kenneth L Nord to motion for summary judgment [19-1], motion for summary adjudication [19-2] (tw) [Entry date 02/16/00]

2/14/00 25 OBJECTIONS by plaintiff Kenneth L Nord to the decal of Raymond Bruca [18-1] (tw) [Entry date 02/16/00]

2/14/00 26 Memo of PA in OPPOSITION by defendant Black & Decker to motion for summary judgment [14-1] (tw) [Entry date 02/16/00]

2/14/00 27 OBJECTIONS by defendant Black & Decker to decls of Freeman Leeth & Lawrence D. Rohlfing [21-1], [16-1] (tw) [Entry date 02/16/00]

2/14/00 28 Separate STATEMENT of genuine issues by defendant Black & Decker in suppt of motion for summary judgment [14-1] (tw) [Entry date 02/16/00]

2/14/00 29 ORIGINAL SIGNATURE PAGE re declaration of Raymond J. Brusca filed 2/7/00 [18-1] by defendant Black & Decker (tw) [Entry date 02/16/00]

2/18/00 30 REPLY memo of PA by defendant Black & Decker in suppt of dfts motion for summary

judgment [19-1], motion for summary adjudication [19-2] (tw) [Entry date 02/24/00]

2/25/00 31 REPLY by plaintiff Kenneth L Nord in suppt of his motion for summary judgment [14-1], & in opp to dfts motion for summary judgment [19-1] (tw) [Entry date 02/29/00]

2/28/00 32 MINUTES: Plfs mot for sum jgm, Dfts mot for sum jgm; Crts tentative ruling is to gr dfts mot, as the crt finds that plf has not met burden as to abuse by dft. Crt abides by its decision & gr dfts mot provisionally. Crt will issue ord re above stated ruing [sic] after fur reflection of oral arguments made. by Judge Carlos R. Moreno CR: Deborah Gackle (tw) [Entry date 02/29/00]

3/22/00 33 ORDER by Judge Carlos R. Moreno granting dfts motion for summary judgment [19-1], granting motion for summary adjudication [19-2], denying plfs motion for summary judgment [14-1]. (ENT 3/23/00), mld ntcs. (tw) [Entry date 03/23/00]

3/22/00 34 JUDGMENT AND ORDER: by Judge Carlos R. Moreno against plaintiff Kenneth L Nord. It is ord that plf sh take nothing by his cmp & that all plfs causes of actn agnst dft alleged therein are dism wi prj. terminating case (MD JS-6). (ENT 3/23/00), mld ntcs. (tw) [Entry date 03/23/00]

4/12/00 35 NOTICE OF APPEAL by plaintiff Kenneth L Nord to 9th C/A from Dist. Court jgm ent 3/23/2000 [34-2] (cc: Lawrence D. Rohlfing, Winston & Strawn) Fee: Paid (dl)

5/5/00	36	NOTIFICATION by Circuit Court of Appellate Docket Number appeal [35-1] 00-55689 (ghap)
6/1/00	37	TRANSCRIPT DESIGNATION and ordering form for dates: 2/28/00 CR: Debra Gackle (ghap) [Entry date 06/05/00]
6/23/00	38	RECEIPT OF TRANSCRIPT of proceedings for the following date(s): 2/28/00 (Re: [35-1]) CR: Deborah Gackle (weap) [Entry date 06/27/00]
6/23/00	–	TRANSCRIPT filed for proceedings held on 2/28/00 (weap) [Entry date 06/27/00]
7/10/00	39	CERTIFICATE of Record Transmitted to USCA (cc: all parties) (weap)
12/12/01	–	PLACED IN FILE – NOT USED re prop order on motion for sumjgm. (yc) [Entry date 01/02/02]
12/12/01	–	PLACED IN FILE – NOT USED stmm of uncontroverted facts and conclusions of law. (yc) [Entry date 01/02/02]
12/20/01	40	NOTICE of change of addr by cnsl by defendant Black & Decker (yc) [Entry date 12/21/01]
8/9/02	–	LODGED CC 9th CCA Jgm of said dist Crt in this cause is rv. (FWD TO CRD) 00-55689 (dl) [Entry date 08/14/02]
8/13/02	41	NOTICE OF REASSIGNMENT Of Case Upon rcpt of Mandate Frm The Ninth Circuit Crt of Appeals. Case randomly reassgned to Judge Terry J. Hatter for all fur procdngs. Case no. now reads as CV 99-408

TJH (CTx) (cc: all counsel) (rn) [Entry date 08/15/02]

8/13/02	–	CASE REOPENED – Purs to Ntc of Reassignment of Case Upon Receipt of Mandate fr the 9th. Cir Court of Appeals (rn) [Entry date 08/15/02]
8/19/02	42	NOTICE OF HEARING: Please take notice that the judgment of the US Court of Appeals for the Ninth Circuit having been rcd in this actn, the mtr of filing & spreading of said judgment is placed on cal for 9/16/02 at 10:00 am bef the Honorable Terry J Hatter, US District Judge, in Courtroom No. 17; It will be necessary for all cnsl to be present by Judge Terry J. Hatter; CR: (n/a) (nhac) [Entry date 08/21/02]
8/26/02	43	ORDER FROM USCA applnt's unopposed mot for atty fees is GR in the amount of $18,154.00. (00-55689) (ghap) [Entry date 09/03/02]
8/27/02	48	RECORD on appeal returned from U.S. Court of Appeals vols: 2; transcripts: 1; Brown folders: 1, doc# 21. (cbr) [Entry date 09/25/02]
9/5/02	44	NOTICE OF MOTION AND MOTION by Kenneth L Nord for attorney fees; PA; decl of Lawrence D Rohlfing; motion hearing set for 10:00 9/30/02 (lc) [Entry date 09/06/02]
9/16/02	45	CERTIFIED COPY of Appellate Court Order: reversing decision of the district Court [Appeal [35-1]; costs raxed on appeal in amt of $628.80 for Kenneth L Nord & agnst Black & Decker Disability Plan (lc) [Entry date 09/18/02] [Edit date 09/18/02]

9/16/02 46 MINUTES: MANDATE from Circuit Court of Appeals reversing decision of USDC & reflecting costs taxed in amt of $628.00 for prevailing pty be fld & spread on rec of this crt (lc) [Entry date 09/18/02]

9/17/02 47 STIPULATION and ORDER by Judge Terry J. Hatter cont hearing on plf motion for attorney fees [44-1] 10/7/02; if dft files timely petition for certiorari w/Supreme Crt from decision of 9th Circuit Crt of Appeals that the matter may be stayed on the filing w/district crt & svc of ntc of filing of petition for certiorari (lc) [Entry date 09/18/02]

11/13/02 49 ORDER by Judge Terry J. Hatter granting plf motion for attorney fees; dft shall pay plf reasonable atty fees of $16,450.00 [44-1] (vacated by 1/8/03 order) (lc) [Entry date 11/14/02] [Edit date 01/09/03]

12/13/02 50 RECEIPT OF TRANSCRIPT of proceedings for the following date(s): 9/16/02 (Re:) CR: Cynthia Mizell (weap) [Entry date 12/16/02]

12/13/02 – TRANSCRIPT filed for proceedings held on 9/16/02 (weap) [Entry date 12/16/02]

1/8/03 51 STIPULATION and ORDER by Judge Terry J. Hatter vacating 11/12/02 order re attorneys fees [49-1] (lc) [Entry date 01/09/03]

MetLife®

January 12, 1998

Met DisAbility
PO Box 3017
Utica, NY 13504

Kenneth Nord
16219 Orange Avenue
Paramount, CA 97023

RE: Disability Benefits
Claim No.: 679801078347
S. S. No.: 502-58-8111
Group No.: 36663
Black & Decker Corp

Dear Mr. Nord:

We are writing in regards to your claim for Disability Benefits.

In order to properly evaluate your claim, we require your physician(s) to provide us with following information:

1. A copy of all office notes which relate to this disability.
2. Current treatment plan; to include medication and dosages and your physical response to treatment.
3. Copies of all lab and diagnostic lab reports i.e.: MRI, CT Scans, X-Rays, etc.
4. Copies of physical therapy progress notes.
5. The enclosed Physician Report of Physical Capacity, completed in its entirety.

In addition, we have enclosed an 'Authorization To Furnish Medical Information" form, a 'Consent For Release Of Information' form and Personal Profile Evaluation form. We ask that you complete and return the enclosed forms. An envelope has been provided for your convenience.

Please note: This information should be submitted within thirty days. Also, the cost for providing this information is the claimant's responsibility.

Sincerely,

Jacqueline White
Case Management Specialist
Met DisAbility
(800) 300-4296

cc: Ray Brusca

PHYSICAL CAPACITIES EVALUATION

NAME OF CLAIMAINT Kenneth Nord SSN 502-58-1030

IMPORTANT: PLEASE COMPLETE THE FOLLOWING ITEMS BASED ON YOUR CLINICAL EVALUATION OF THE CLAIMANT AND OTHER TESTING RESULTS. ANY ITEM THAT YOU DO NOT BELIEVE YOU CAN ANSWER SHOULD BE MARKED N/A (NOT ANSWERABLE)

NOTE: In terms of an 8 hour workday. "Occasionally" equals 1% to 33%; "Frequently," 34% to 66%; "Continuously," 67% to

I. *In an 8-hr. workday, claimant can:* (*Circle full capacity for each activity*)

TOTAL AT ONE TIME

A.) Sit	—	0	—	[1,]	2,	3,	4,	5,	6,	7,	8, (hrs.)
B.) Stand	—	0	—	1,	2,	3,	4,	5,	6,	7,	8, (hrs.)
C.) Walk	—	0	—	1,	2,	3,	4,	5,	6,	7,	8, (hrs.)

TOTAL DURING ENTIRE "8-HOUR" DAY

A.) Sit	—	0	—	[1,]	2,	3,	4,	5,	6,	7,	8, (hrs.)
B.) Stand	—	0	—	1,	2,	3,	4,	5,	6,	7,	8, (hrs.)
C.) Walk	—	0	—	1,	2,	3,	4,	5,	6,	7,	8, (hrs.)

II. *Claimant can lift:*

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A.) Up to 5 lbs.	☐	☒	☐	☐
B.) 6-10 lbs.	☒	☐	☐	☐
C.) 11-20 lbs.	☒	☐	☐	☐
D.) 21-25 lbs.	☒	☐	☐	☐
E.) 26-50 lbs.	☒	☐	☐	☐
F.) 51-100 lbs.	☒	☐	☐	☐

III. *Claimant can carry:*

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A.) Up to 5 lbs.	☐	☒	☐	☐
B.) 6-10 lbs.	☒	☐	☐	☐
C.) 11-20 lbs.	☒	☐	☐	☐
D.) 21-25 lbs.	☒	☐	☐	☐
E.) 26-50 lbs.	☒	☐	☐	☐
F.) 51-100 lbs.	☒	☐	☐	☐

IV. *Claimant can use hands for repetitive action such as:*

	SIMPLE GRASPING		PUSHING & PULLING OF ARM CONTROLS		FINE MANIPULATION	
A.) Right	☑ Yes	☐ No	☑ Yes	☐ No	☑ Yes	☐ No
B.) Left	☑ Yes	☐ No	☑ Yes	☐ No	☑ Yes	☐ No

V. *Claimant can use feet for repetitive movements as in pushing and pulling of leg controls:*

RIGHT		LEFT		BOTH	
☐ Yes	☑ No	☐ Yes	☑ No	☐ Yes	☑ No

VI. *Claimant is able to:*

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A.) Bend	☐	☑	☐	☐
B.) Squat	☐	☑	☐	☐
C.) Crawl	☐	☑	☐	☐
D.) Climb	☐	☑	☐	☐
E.) Reach	☐	☑	☐	☐

VII. *Restriction of activities involving:*

	NONE	MILD	MODERATE	TOTAL
A.) Unprotected heights	☒	☐	☐	☐
B.) Being around moving machinery	☒	☐	☐	☐
C.) Exposure to marked changes in temperature & humidity	☐	☒	☐	☐
D.) Driving automotive equipment	☒	☐	☐	☐
E.) Exposure to dust, fumes & gases	☒	☐	☐	☐

REMARKS ON ABOVE OR OTHER FUNCTIONAL LIMITATIONS.

SIGNATURE — DR. /s/ Lytton Williams

PRINT — NAME Lytton Williams M.D.

DATE 4/2/98

BEST AVAILABLE COPY

LAW OFFICES OF
LAWRENCE D. ROHLFING
12631 EAST IMPERIAL HIGHWAY, SUITE C-115
SANTA FE SPRINGS, CALIFORNIA 90670

LAWRENCE D. ROHLFING

MARC V. KALAGIAN
DENISE L. BOURGEOIS
YOUNG C. CHO
BRIAN C. SHAPIRO

TELEPHONE
(562) 868-5886
FACSIMILE
(562) 868-5491

April 21, 1998

Group Claims Review
Metropolitan Life Insurance Company
Post Office Box 6146
Utica, New York 13504

RE: Kenneth Nord
SSN: 502-58-1030
Claim No.: 679801078347

Dear Group Claims Review:

This letter follows up on my correspondence to you of March 25, 1998. At that time, I invoked and confirmed the review previously initiated by Kenneth Nord. I requested further explanation of the specific reasons for denial, requested identification of the information necessary to perfect the claim, requested in [sic] a copy of all pertinent portions of your claim file, and requested in [sic] opportunity to review and analyze the policy of insurance covering the plan.

Since writing to you at that time, I have secured additional information. I enclose a statement of physical capacity from Dr. Hartman April 9, 1998. Dr. Hartman

states that Kenneth Nord has an extremely limited capacity for sitting, can only lift up to five pounds occasionally, cannot use the lower extremities, and can only occasionally bend, squat, crawl, climb, or reach. In addition to the physical therapy evaluation, I enclose the complete records secured from Dr. Hartman. These documents reflect ongoing treatment for a disabling back condition. You will note that Dr. Hartman is the primary physician and not the orthopedist. The records do contain an MRI study dated August 1, 1997, indicating the presence of degenerative disc disease at L4-5 and L5-S1 with disc desiccation. Dr. Hartman has consistently expressed the opinion that Kenneth Nord is not able to work both on August 13, 1997, and on March 23, 1998, at both levels.

I have also secured an estimate of physical capacity from Dr. Williams. He expresses the same opinions, clarifying that the limitation in lifting includes carrying. That capacity evaluation is dated April 2, 1998. Included in the records of Dr. Hartman referenced above, are reports from Dr. Williams to Dr. Hartman. On January 23, 1998, Dr. Williams noted the presence of decreased range of motion and muscle spasm. I will secure and present the complete records from Dr. Williams, including his chart notes.

Thank you for your attention and cooperation. Should you wish to discuss the matter telephonically, please do not hesitate to call me.

Very truly yours,

/s/ Lawrence D. Rohlfing (kh)
Lawrence D. Rohlfing
Attorney for Kenneth Nord

LDR:sk

cc: Kenneth Nord

Enclosures

May 7, 1998

MetLife
5950 Airport Road
PO Box 6146
Utica, New York 13504

Law Offices of
Lawrence D Rohlfing
12631 East Imperial
Highway, Suite C-115
Santa Fe Springs, CA 90670

RE:
Long Term Disability
SS No: 502-58-1030
Group No: 36663
Claim No: 679801078347
Claimant: Kenneth Nord

Dear Mr. Rohlfing

We have received your correspondence dated April 21, 1998 and the additional medical records on Mr. Nord in regard to his Long Term Disability claim.

Please be advised we are reviewing this information along with all the other information on file. As soon as a determination is made, you will be advised accordingly.

Sincerely,

/s/ Kim Ferguson
Kim Ferguson
Senior Case Management Specialist
Met DisAbility
(800) 300-4296

LAW OFFICES OF
LAWRENCE D. ROHLFING
12631 EAST IMPERIAL HIGHWAY, SUITE C-115
SANTA FE SPRINGS, CALIFORNIA 90670

LAWRENCE D. ROHLFING
———————
MARC V. KALAGIAN
DENISE L. BOURGEOIS
YOUNG C. CHO
BRIAN C. SHAPIRO

TELEPHONE
(562) 868-5886
FACSIMILE
(562) 868-5491

June 19, 1998

Jacqueline White
Disability Claims Manager
Metropolitan Life Insurance Company
Post Office Box 3017
Utica, New York 13504

RE: Kenneth Nord
Claim No.: 679801078347
SSN: 502-58-1030
Employer: Black & Decker Corp.

Dear Ms. White:

Thank you for your letter of April 21, 1997. I'm experiencing some difficulty in getting a copy of the long-term disability plan from Black & Decker. I have gotten every other plan that they have but not the long-term disability plan. I expect to receive it shortly.

I did receive some additional records from Dr. Williams. Enclosed are the results of the discogram conducted on March 26, 1998. Please note the positive findings of concordant pain. This should provide you with a better basis for allowing the claim than previously presented.

I have also had the opportunity to review the records that you sent. The charge notes confirm the presence of low back pain, positive signs, and need for ongoing treatment. Kenneth Nord has positive electrodiagnostic studies to confirm the neurological involvement. He also has disc desiccation. Kenneth Nord has used a variety of pain, anti-inflammatory, and other medications for his severe orthopedic condition. Even as of January 15, 1998, Kenneth Nord could not even serve on a jury.

At this juncture, I am confused as to why metropolitan denied the claim for benefits. It is apparent to me that Kenneth Nord suffers from a severe orthopedic condition resulting in an inability to engage in either prolonged sitting or prolonged weightbearing, both required of substantial work activity. Please advise.

Thank you for your attention and cooperation. Should you wish to discuss the matter telephonically, please do not hesitate to call me.

Very truly yours,

/s/ Lawrence D. Rohlfing (kh)
Lawrence D. Rohlfing
Attorney for Kenneth Nord

LDR:sk

cc: Kenneth Nord

June 22, 1998

MetLife
Met Disability
5950 Airport Road
PO Box 3017
Oriskany, NY 13424

Kenneth Nord
16219 Orange Ave.
Paramount, CA 90723

Firm: Black & Decker
Group No.: 36663
Employee I.D. No.: 502-58-1030

RE: T.C. Prentice, M.D. Consultant In: Neurology
Address: 11525 Brookside Ave.
Suite 400
Downey, CA 90241

Appointment Date: 7/17/98 Time: 12:15 PM
Telephone No.: (781) 272-6612

Dear Mr. Nord:

In accordance with the terms of your Group Plan, we have requested the above-named physician to examine you as our Consultant on the appointment date and time shown above.

The reason for this examination is that we would like to have an independent evaluation of your condition to help us in the administration of your claim. Please understand, that we are not, in any way, questioning the integrity or ability of your own physician.

Please confirm your appointment of July 17, 1998 by telephone (781) 272-6612, as soon [sic] you receive this letter.

In addition, please give the physician your telephone number so that you can be contacted in the event it becomes necessary to change your appointment date. If a different appointment is schedule, please advise us of the new date. If for any reason, you are unable to keep your appointment, please notify the doctor's office at least 48 hours before the appointment and also *telephone our office (800) 300-4296 advising why you cannot keep this appointment.*

Please bring to this examination any x-rays, medical reports or test results regarding your disability.

Yours truly

Kim Ferguson
Case Management Specialist
Met DisAbility
1-800-300-4296 ext. 2478

LAW OFFICES OF
LAWRENCE D. ROHLFING
12631 EAST IMPERIAL HIGHWAY, SUITE C-115
SANTA FE SPRINGS, CALIFORNIA 90670

LAWRENCE D. ROHLFING

MARC V. KALAGIAN
DENISE L. BOURGEOIS
YOUNG C. CHO
BRIAN C. SHAPIRO

TELEPHONE
(562) 868-5886
FACSIMILE
(562) 868-5491

August 6, 1998

Kim Ferguson
Disability Claims
Metropolitan Life Insurance Company
Post Office Box 3017
Utica, New York 13504

RE: Kenneth Nord
Claim No.: 679801078347
SSN: 502-58-1030
Employer: Black and Decker Corp.

Dear Ms. Ferguson:

This letter will serve to inquire as to the status of the above matter. I wrote to Jacqueline White on June 19, 1998. I provided additional records at that time. I have also been advised that on that date you set an evaluation of Kenneth Nord with Dr. Prentice for July 17, 1998.

I would appreciate a response to my letter of June 19. I would also like to have in [sic] opportunity to review, analyze, and comment upon the report of Dr. Prentice. I have also now received a copy of the pertinent plan document.

Like many policies, this one carries two different definition [sic] of total disability dependent upon the time

frame at issue. The issue in this case deals with the own occupation definition of disability. Kenneth Nord ceased work on July 15, 1997. We are just now 12 months beyond the onset of disability.

Kenneth Nord worked for Black & Decker as a material planner. He lifted between 25 and 60 pounds. He spent slightly less than half the day standing and walking and the rest of the time sitting. According to the employer statement, lifting never exceeded 20 pounds and even then only on an occasional basis. The work does require a maintenance of the head and neck in a static position for up to 2 hours in a day and the same frequency for looking up and looking down.

Kenneth Nord does suffer from degenerative disc disease at L4-5 and L5-S1 with disc desiccation. MRI study dated July 30, 1997. Kenneth Nord has received consistent treatment from Dr. Hartman for back pain since his cessation of work activity. In fact, the medical records in your claim file demonstrate that Kenneth Nord received significant treatment and made his best effort to continue to work despite the presence of back pain prior to July 15, 1997. On January 15, 1998, Stanley Katz, MD stated that Kenneth Nord could not serve on a jury for three months because of the pain. Obviously, sitting on a jury has less physical strain than the job of a material handler for Black & Decker.

Kenneth Nord has had physical therapy and a broad array of medication. Electrodiagnostic studies of the lower extremities demonstrate the existence of nerve impingement. Although filed, both the EMG and the nerve conduction studies or abnormal suggestive of radiculopathy. Please remember in this regard that the employer has

stated that the work as material handler requires continuous interpersonal relationships and frequent exposure to job stress. It is difficult to imagine an individual in significant pain with radiculopathy having the prolonged and sustained capacity to function in that environment.

Pain can be both exertional and nonexertional. It also depends on the focus of the work activity. Even if we assume for the sake of argument that Kenneth Nord could perform the physical requirements of his work, the question becomes whether the pain would significantly interfere with his capacity to engage in the mental requirements of that work. The pain was so significant that Kenneth Nord could not sit on a jury, hear testimony, and make an informed decision. I am quite certain that Black & Decker would insist on the same degree of mental precision in the carrying out of the functions of a material handler.

This discussion is entirely consistent with the discogram ordered by Dr. Williams. The discogram demonstrated concordant pain after injection at L4-5 and L5-S1. The CT scan of the lumbar line revealed annular thinning of the intervertebral discs and loss of disc space at both levels. These studies in conjunction with the electrodiagnostic studies provide an objective basis for the conclusion that Kenneth Nord suffers from a pain syndrome that would interfere with his capacity to engage in the mental requirements of work.

I want to clarify these issues with the employer and with the current treating physician. I will supplement the record once I have had the opportunity to review and comment upon the opinion of Dr. Prentice. Please expedite

your transmittal of that report so that I can do my job as well.

Thank you for your attention and cooperation. Should you wish to discuss the matter telephonically, please do not hesitate to call me.

Very truly yours,

/s/ Lawrence D. Rohlfing (kh)
Lawrence D. Rohlfing
Attorney at Law

LDR:sk

cc: Kenneth Nord

October 15, 1998

MetLife
5950 Airport Road
PO Box 6146
Utica, New York 13504

Ray Brusca
Vice President of Benefits
Black & Decker Corp.
TW 170
701 East Joppa Road
Towson, MD 21286

RE:
Long Term Disability
Claim No: 679801078347
Group No: 36663
SS No: 502-58-1030
Claimant: Kenneth Nord

Dear Mr. Brusca

We have completed a review of Mr. Nord's Long Term Disability claim.

Based on this medical information in our possession, we find he does not meet the definition of disability as denied in your Group Plan. Therefore, we recommend the previous denial of benefits be upheld.

A copy of all the information considered is attached for your review.

The attached draft reply for your consideration is based upon our understanding of your plan and how the claim under consideration relates to that plan. As claims fiduciary, you must inform the claimant (or his representative) of your final decision in this matter. Please advise this office of your decision with a copy of your letter.

Yours Truly,

/s/ Kim Ferguson
Kim Ferguson
Senior Case Management Specialist
Met Disability
(800) 300-4296 ext 2478

DRAFT

October 15, 1998

Law Offices of
Lawrence D Rohlfing
12631 East Imperial
Highway, Suite C-115
Santa Fe Springs, CA 90670

RE:
Long Term Disability
Claim No: 679801078347
Group No: 36663
SS No: 502-58-1030
Claimant: Kenneth Nord
Black & Decker

Dear Mr. Rohlfing

We have completed the full and fair review of the denial of Mr. Nord's Long Term Disability claim. For the reasons noted below, it is our determination that the denial of your claim was proper and we therefore must uphold the denial decision.

As previously indicated to you, the Black and Decker Disability Plan defines disability as "the complete inability of a Participant to engage in his regular occupation with the employer during the first thirty months of disability, and beginning with the thirty-first month of disability, the Participant's complete inability to engage in any gainful occupation or employment with any employer for which the Employee is, as of his disability date, reasonably qualified by education, experience or training."

We have thoroughly reviewed all the medical and vocational information in our possession. Mr. Nord's date last work [sic] as a material handler was July 15, 1997 due to a diagnosis of degenerative disk disease and chronic low back pain.

Mr. Nord's attending physician Dr. Williams provided restrictions dated April 7, 1998. He indicated Mr. Nord

could sit for one hour during an 8 hour day, lift and carry up to 5 pounds occasionally, can use his hands, but not his feet for repetitive movements and can bend, squat, crawl, climb and reach occasionally. Another attending physician, Dr. Leo Hartman also provided restrictions. Dr. Hartman indicated on April 9, 1998 the same restrictions as Dr. Williams.

An X-ray dated March 10, 1997 of the hips and pelvis were negative. The lumbosacral spine x-ray of the same day revealed no evidence of acute process, mild degenerative changes of lower lumbar spine and mild degenerative disc disease at L4-L5-S1. An MRI dated July 30, 1997 of the lumbar spine revealed degenerative disc disease at L4-L5-S1 with disc desiccation and mild diffused bulge. There was no disc herniation, neural foramina or central canal stenosis. An EMG/NCS dated November 17, 1997 documents abnormal examination suggestive of mild bilateral L5 radiculopathy.

Mr. Nord attended an independent medical examination with Dr. Antoine Mitri on July 17, 1998. It was Dr. Mitri's opinion that Mr. Nord's [sic] does present with degenerative disk disease and chronic myofascial pain syndrome, however his general and neurological examination are essentially normal. The tests performed essentially show no evidence of lumbosacral nerve root compression, even though the EMG and NCS showed bilateral L5 radiculopathy, this was stated to be mild and were not confirmed by the LS MRI that did not show root compression.

This examination report was forwarded to your office on August 7, 1998 and September 15, 1998 asking that you provide Mr. Nord's attending physician with a copy and

provide his comment. To date, we have not received a response.

Based on our review, the medical supports Mr. Nord's ability to return to work at his own occupation, therefore, he can not be considered totally disabled as defined by his Group Plan.

This determination is the final decision on review and constitutes completion of the full and fair review required by Mr. Nord's Plan and federal law.

Should you wish to pursue this matter further, you should consult the information provided concerning his rights, as set forth in his Summary Plan Description ("SPD"). A copy of the SPD may be obtained by contacting the Human Resource or Personnel Division of Mr. Nord's employer.

Please be advised that under the provisions of his Plan, no further administrative appeals are available to him concerning his disability benefit.

KWIKSET CORPORATION

JOB DESCRIPTION

Job Code: KX016 Grade: XX 3

First Level Mgmt	Date	Compensation	Date
Second Level Mgmt	Date	Human Resources	Date

TITLE: Material Planner

LOCATION: Anaheim or Bristow

REPORTS TO: Materials Manager

SUPERVISES: None

WORKING RELATIONSHIPS: Inventory Control Clerks, Material Control Expeditor, Inventory Control Specialists, Production Schedulers.

SUMMARY: The Material Control Specialist controls and maintains inventory levels by ordering goods and interacting with vendors using spreadsheets.

MAJOR DUTIES AND RESPONSIBILITIES (ESSENTIAL FUNCTIONS):

1. Interacts with vendors on a daily basis in order to ensure prompt and correct delivery of goods ordered. Works with vendors to resolve any shipping and order problems.
2. Controls inventory ordered and ensures goods are purchased at reduced costs. Maintains adequate supply of goods in stock, ordering when necessary.
3. Purchases sufficient quantity of goods and supplies staying within budgetary limits and storage capacity.

4. Generates spreadsheet to determine appropriate levels of inventory. Determines inventory level needed based upon production plans.

TITLE: Material Control Specialist

5. For physical/psychological requirements and working conditions see form HR 612-20.

ADDITIONAL DUTIES AND RESPONSIBILITIES:

Other duties as required by supervisor.

EMPLOYEE SPECIFICATIONS:

Bachelor's degree or equivalent. Position requires knowledge of MRP and MPS which is typically obtained through 5 years of related experiences. Knowledge of Harvard Graphics and spreadsheets is also required.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

THE HONORABLE CARLOS R. MORENO,
UNITED STATES DISTRICT JUDGE

KENNETH L. NORD, PLAINTIFF,	)	
VS.	)	CV 99-0408 CM
THE BLACK & DECKER DISABILITY PLAN, DEFENDANT.	)	

REPORTER'S TRANSCRIPT OF PROCEEDINGS

LOS ANGELES, CALIFORNIA

MONDAY, FEBRUARY 28, 2000

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT
DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

DEBORAH K. GACKLE, CSR, RPR
Official Court Reporter
U.S. District Court
312 North Spring Street
Room 402-A
Los Angeles, CA 90012

[2] **APPEARANCES:**

FOR THE PLAINTIFF:

LAW OFFICES OF LAWRENCE ROHLFING
BY: LAWRENCE ROHLFING
12631 East Imperial Highway
Suite C115
Santa Fe Springs, California 90670

FOR THE DEFENDANT:

WINSTON & STRAWN
BY: LEE T. PATERSON
444 South Flower Street
Los Angeles, California 90071-2911

[3] LOS ANGELES, CALIFORNIA; MONDAY, FEBRUARY 28, 2000; 9:25 A.M.

THE CLERK: Item No. 1, civil, 99-0408, Kenneth L. Nord versus The Black & Decker Disability Plan.

Counsel, please state your appearances for the Court.

MR. PATERSON: Good morning, Your Honor. My name is Lee Paterson for Black & Decker.

THE COURT: Good morning.

MR. ROHLFING: Good morning, Your Honor. Lawrence Rohlfing on behalf of the plaintiff, Kenneth Nord.

THE COURT: Good morning.

Matter is here also on a cross-motion for summary judgment, and the Court has read and considered the

motions. I'll announce my tentative, and I'll entertain argument.

My tentative is to grant the defendant's motion and deny plaintiff's motion. First, on the – however, on the issue of exhaustion of administrative remedies, to the extent that defendant raises that as a defense, that part of the motion is denied.

I think, given the plan documents and the provision for internal appeal, that the plaintiff is correct in his claim that all the appropriate admistrative [sic] remedies were exhausted.

To the extent that there's any ambiguity in whether or not the remedies were exhausted internally, I think that [4] ambiguity should be interpreted in favor of the plaintiff.

However, as to the balance of the issues raised, I'm going to rule in favor of the defendant. To the extent that there is an apparent conflict of interest, it doesn't appear that that apparent conflict of interest had any material effect on the ultimate decision.

So applying a less deferential standard of abuse of discretion, and in reviewing the merits of the case, I don't believe at this time that plaintiff has really sustained its burden to show that there was any abuse by the plan.

The two things that are pointed out: The analysis or the opinion of the human resources evaluator, I think, one, that is insufficient, and, second, there's nothing about the IME that creates any question as to whether or not there was anything inappropriate or a misanalysis of the plaintiff's condition.

So those are my tentative comments. I'll have more. So I'll hear first from counsel for Mr. Nord.

MR. ROHLFING: Thank you, Your Honor.

With respect to the conflict-of-interest issue, and also with respect to the opinion of Ms. Forward in her statement under penalty of perjury abut the impact of paying, the record is clear that is before the court that Mr. Brusca made his decision not based upon Dr. Mitri's report in conjunction with Ms. Forward's statements under penalty of perjury, he added something else to the mix, and that something else to the mix is [5] still not before the court. That is the statement of Ms. Forward in a telephone conversation with Mr. Brusca.

And so Black & Decker has put both Mr. Nord and the Court in a situation of trying to guess what is inside of a black box and saying, "Well, we know two-thirds of it goes into the black box, and we know all of it comes out of the black box. And so in the broad scheme of things, it appears that it's reasonable."

Well, Your Honor, I would hope that you would reconsider that because full and fair review has to be fair. It's not a game of five-card stud where the plan gets to hold one card face down and never disclose it.

Even now, even now as we stand here in court, we do not know the substance of the conversation that Mr. Brusca had with Ms. Forward. He has stated that he relied on that statement, and still, in his declaration, refuses to disclose it.

Your Honor, I would submit to you that is ample evidence, in light of Tremain, for you to conclude that the

apparent abuse of – the apparent conflict of interest has affected the decision-making process.

Black & Decker has made a decision within the plan. The final decision does not cite this conversation. We still don't know what the conversation is.

Black & Decker is hiding something, and Your Honor should not countenance Black & Decker's failure to disclose all [6] of the material evidence because the failure to disclose robs the decision-making process of the earmarks of being fair. And that's required by the statute and also required by the regulations.

With respect to Dr. Mitri's opinion – and I think this is fairly well set out in the brief – Dr. Mitri found that Mr. Nord suffers from a myofacial pain syndrome, and the question is one of magnitude. And Dr. Mitri is not clear about the magnitude of pain.

The 9th Circuit in other areas of law has been very clear that pain can be both nonexertional and exertional. There are Penny v. Sullivan, Perminter v. Heckler, there's Desrosiers v. Secretary.

In all of those cases, the 9th Circuit has clearly stated that pain can be exertional, it can interfere with an individual's ability to engage in the physical requirements of work.

And in this case, according to Dr. Ebeling and Dr. Mitri, Kenneth Nord is limited to sedentary work. That is a pretty significant limitation on his ability to engage in physical activity.

Dr. Mitri's also stated that he suffers from a pain syndrome. And we know from the employer's statement

that Ms. Forward filled out at the beginning of the claim, that this is a job that requires intense interpersonal communications.

[7] And I would submit to Your Honor that it doesn't make sense that an individual that is suffering from a chronic myofacial pain syndrome, that is occasionally resorting to Darvocet, that is occasionally resorting to other narcotic medication, could be expected to, on a continuous basis, deal with the stress, to deal with the interpersonal communication requirements of the job of a material planner; and that is exactly what Ms. Forward endorsed on her statement.

And so we have the treating physician opinions that answer the question, we have Dr. Mitri's opinion that is, at best, ambiguous on the frequency and intensity of the pain, and we have Ms. Forward saying, assuming that it's occasionally moderate, which I think is a pretty low level of threshold of pain, he can't perform his usual and customary job.

I would submit, Your Honor, that Mr. Nord has sustained his burden of proof. He did submit the evidence necessary to prove that he could not do his usual and customary job to the plan, and for the plan to rely on extra record evidence is inexcuseable.

THE COURT: Let me hear from Black & Decker.

MR. PATERSON: Yes, Your Honor.

The difficulty with the plaintiff's argument to you is that in both cases, he ignores the fact that the plaintiff was using drugs, legal drugs, to control his pain.

In the first case, the plaintiff submitted a incomplete [8] hypothetical to Ms. Forward, asked her could – would he – could he do work which required interpersonal relationships, intense interpersonal relationships, if he was under pain.

Didn't ask him the question, which he should have asked him, could he control that pain by using drugs, and, therefore, not have a problem with these intense interpersonal relationships.

Got the answer no, and then brought that document to this Court and asked this Court to consider an incomplete hypothetical as proof of the fact that the employee couldn't do the job.

It's clearly not proof of the fact that the employee can't do the job. The employee has been prescribed drugs. Those drugs are to control the pain.

Purpose of controlling the pain is so that the employee can perform his job and live his life, clearly what he is doing in this case. That is what Mr. Brusca took into account.

Mr. Brusca first made his decision without considering the human resource administrator's decision at all. He was then asked to reconsider his decision based on this incomplete hypothetical.

He reconsiders his decision, he did talk to Ms. Foreman [sic], and he didn't change his opinion. Since that incomplete hypothetical is not admissible in this case – at least we argue it's not admissible in this case – it makes no [9] difference whether he revealed what Ms. Foreman said to him or not. It's –

THE REPORTER: Can you please slow down.

THE COURT: Slow down.

MR. PATERSON: Yes. I'm very sorry.

It's [sic] makes no difference whether – what Ms. Foreman said to him or didn't say to him because the hypothetical is improper.

Same argument, same – similar situation in regard to Dr. Mitri's opinion. Dr. Mitri made an opinion that he has periodic pain and that he is capable of performing a sedentary job, that that job does periodically require certain kinds of physical and intellectual stimulation.

Dr. Mitri doesn't opine as to whether that intellectual stimulation or physical stimulation would be affected at all by the fact that he cuold [sic] take a drug to relieve the pain or relieve himself of the symptoms of that pain.

And, therefore, again, plaintiff ignores the fact that the plaintiff has been given prescriptions for drugs to control the pain so he can engage in a useful life.

Mr. Brusca obviously took that into effect and properly denied the claim and under a substantial evidence test should not be reviewed by this Court again. Thank you.

THE COURT: You can reply briefly.

MR. ROHLFING: Your Honor, there are disability cases; [10] there are disability policies; there are thousands of disability cases pending in this court and in the 9th Circuit and every other court in this country for one reason: Because medicine is not 100 percent effective.

And for Mr. Nord to take narcotic pain medication and to simply – imply that that – that instantly he would have the ability to engage in the full-blown mental requirements of intense interpersonal communications in dealing in stressful situations I think is, at best, naive.

If an individual has a chronic pain syndrome and he just starts to develop the occasional moderate pain that is assumed in the hypothetical question that's posed to Ms. Forward and takes the narcotic medication, it isn't reasonable to assume that he would then be able to continue in the intense interpersonal communications and dealing with the stressful situations that the employer's stated is required of this job. He has to have – you have to have some reasonable amount of time for the medication to take effect.

And the important factor to consider with respect to this new allegation in court that the hypothetical question to Ms. Forward was incomplete, is that the regulations require that the plan administrator advise Mr. Nord of any additional evidence that is necessary to perfect his claim.

And I think that that carries with it a compounded view to advise Mr. Nord, We don't think that this evidence is quite [11] enough. You haven't included the medication issue.

There is an issue of side effects, there is an issue of time it takes the pain medication to take hold and what the residual capacity for the mental requirements of work Mr. Nord would have, both with the onset of moderate pain and the use of narcotic medication.

And it goes back to full and fair review. The administrative proceedings are not adversarial. The plan is required to assist the claimant for benefits in perfecting his claim, and the plan didn't do that here. Thank you.

THE COURT: Anything further?

MR. PATERSON: No, Your Honor.

THE COURT: I'll take counsel's arguments under submission. I think I'm going to go ahead with my tentative, but I just want to reflect a little bit more on one particular issue of the conversation between Brusca and the human resources evaluator.

MR. ROHLFING: Thank you, Your Honor.

MR. PATERSON: Thank you, Your Honor.

(Proceedings concluded at 10:38 a.m.)

STATE OF CALIFORNIA

CV 99-0408 CM

COUNTY OF LOS ANGELES

I hereby certify that the foregoing matter, entitled KENNETH L. NORD versus BLACK & DECKER DISABILITY PLAN, is transcribed from the stenographic notes taken by me and is a true and accurate transcription of the same.

/s/ Deborah K. Gackle — June 20, 2000
Deborah K. Gackle — Date
CSR No. 7106

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(3)

Supreme Court, U.S.
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No. 02-469

In The

Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

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QUESTION PRESENTED

Whether the Ninth Circuit erred in holding that an ERISA disability plan administrator's determination of disability is subject to the "treating physician rule" and, therefore, the plan administrator is required to accept a treating physician's opinion of disability as controlling unless he rebuts that opinion based upon substantial evidence on the record.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit filed on July 15, 2002 is reported at 296 F.3d 823 (2002). The opinion of the United States District Court for the Central District of California was issued on March 22, 2000 and is unreported. [Petition App. 18-36][1]

JURISDICTION

The judgment of the Ninth Circuit was entered on July 15, 2002. [Petition App. 1-7] The Petition for Writ of Certiorari was filed on September 19, 2002, and was granted on January 10, 2003. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1104, 1109, 1132(a)(1)(B), 1133 (2002).

STATEMENT OF THE CASE

There is no dispute that Respondent, Kenneth L. Nord, a former material planner for Kwikset Corporation ("Kwikset"), has mild spinal degeneration. This case arises

[1] The Appendix to Petition for Writ of Certiorari, filed on September 19, 2002, is referred to hereafter as "Petition App." followed by the page number.

from a dispute over whether or not Respondent's spinal degeneration has caused him back pain that is so severe he can not perform his regular occupation even with accommodation and/or with the use of pain suppressing medication.

Respondent's treating physician, Dr. Hartman, an internist, found that he is physically impaired.[2] Four examining physicians for Respondent determined that Respondent has mild spinal degeneration. An examining neurologist, Dr. Mitri, found that Respondent has spinal degeneration and chronic pain and also found after reviewing his job description that Respondent can, nevertheless, perform the duties of his job if he is permitted to stand and walk periodically. The plan administrator, after reviewing all of the medical opinions, the medical records, the requirements of the job and Respondent's employment history found that Respondent's impairment did not meet

[2] The Ninth Circuit erroneously found that Respondent had three treating physicians' opinions. *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 832 (2002). In fact, the evidence on the record is that Respondent had two treating physicians, Dr. Hartman and Dr. Silva, only one of which, Dr. Hartman, made a diagnosis of Respondent's impairment. *See* Lodging for Petition for Writ of Certiorari filed September 19, 2002 referred to hereinafter as "L." followed by the page number. [L:53, 81] Dr. Silva only provided his progress notes with indecipherable references to diagnoses. [L:83-94] In addition, Respondent saw Dr. Williams, from whom there were no notes, no test results and no diagnosis. Dr. Williams referred Respondent to Dr. Go. Dr. Williams also signed a Physical Capacities Evaluation for Respondent. [L:83] There is no evidence on the record that Dr. Williams treated Respondent. Dr. Silva also had an associate, Dr. Katz, who examined Respondent on one occasion, but made no report. [L:95] Respondent had three other examining physicians, Dr. Go who conducted a CT scan and a discogram, Dr. Zandpour who conducted x-rays and an MRI, and Dr. Ali who conducted an electromyography (EMG). [L:49-52, 73-75, 97-100]

the plan's disability definition of "the complete inability . . . of a participant to engage in his regular occupation with the Employer." [L:20,155-156] In the words of Learned Hand, "[a] man may have to endure discomfort or pain and not be totally disabled; much of the best work of life goes on under such disabilities." *Theberge v. United States*, 87 F.2d 697, 698 (2nd Cir. 1937).

A. Petitioner's Plan And Respondent's Job

The Black & Decker Corporation ("Black & Decker"), the parent of Kwikset, voluntarily maintains a disability plan ("the Plan") for its employees. The Plan provides a short-term disability benefit for 30 months to disabled employees.[3] [L:7] The plan narrowly defines "disability" for purposes of the 30 months of benefits as "the complete inability (whether physical and/or mental) of a participant to engage in his regular occupation with the Employer." [L:20, 23] The Plan designates the Plan Manager as the administrator. [L:15] The Plan does not require the Plan Manager to defer to the findings of an employee's treating physician; rather, it provides that the "determination of Disability shall be made by the Plan Manager based on suitable medical evidence and a review of the Participant's prior employment history that the Plan Manager deems satisfactory in its sole and absolute discretion." [L:20]

The Plan Manager, Ray Brusca, is Black & Decker's Vice-President of Benefits. [L:17] He has delegated some of

[3] The Plan also provides a long-term disability benefit which is not involved in this case. [L:7]

his administrative functions to Metropolitan Life Insurance Company ("MetLife"). [L:26]

Respondent was a material planner working for Kwikset. Respondent's duties as a material planner included ordering goods, interacting with vendors and maintaining inventory levels. [Petition App. 90] His job was sedentary. [Petition App. 92-93] It involved up to six hours of sitting and up to two hours of standing or walking. [L:143] Respondent's job did not require him to climb, twist, bend over, crouch, stoop, balance, reach above shoulder level, push or pull, grasp, or make repetitive motions with hands or feet. *Id.* His job description provided that occasionally he was required to carry up to 20 pounds, but never more. *Id.*

B. Respondent's Disability Claim

Respondent's treating physician since early 1993 was Dr. Hartman, an internist. [L:65] Dr. Hartman treated Respondent for general medical problems such as stomach upsets, sore throats and ear infections. [L:62-65] In early 1997, Respondent complained to Dr. Hartman about back pain. [L:61] Dr. Hartman referred Respondent to Bellwood Imaging Center where he was given an MRI and diagnosed with 1) mild degenerative changes of the lower lumbar spine and 2) mild degenerative disc disease. [L:73-74]

Respondent stopped working on July 15, 1997. [Petition App. 91] To support his leave of absence from work, he submitted a letter from Dr. Hartman stating a diagnosis of "lumbar disc syndrome." [L:81, 84] Respondent later submitted a claim for weekly disability benefits under the Plan. [Petition App. 91] There is no record evidence that

Respondent was prescribed or tried pain relieving medication for his back pain prior to leaving work.

In August, 1997, Dr. Hartman referred Respondent to Dr. Silva, an orthopedic surgeon. [L:57] Dr. Silva, in turn referred Respondent to Dr. Ali for nerve conduction studies and an EMG. Dr. Ali's diagnosis is "mild bilateral (L:5) radiculopathy." [L:97-99] Dr. Silva's only diagnosis of Respondent's condition is made in indecipherable references in his Progress Notes. [L:89-94]

On January 17, 1998, Respondent filled out a Personnel Profile Evaluation stating that he went fishing regularly, mowed the lawn, did housework and was able to care for his own personal needs (washing, bathing, dressing, etc.). [L:139-140]

Dr. Hartman's medical records show that Respondent was on medication for his back pain beginning in August 1997. [L:94] Dr. Silva's records concur that "medication helps" his pain, he "feels worse without medication" but it is "tolerated with medication," and that his "symptoms are controlled with Relafen, occasional Darvocet and Flexeril." [L:68, 87, 89] The records show prescriptions for Relafen, Darvocet and Flexeril. [L:104-108, 111-112, 114-115, 137]

C. Denial Of Benefits And Review Of The Denial

After a review of Respondent's medical records, MetLife denied benefits to Respondent on the grounds he was not totally disabled from performing his own job. MetLife referred to the fact that Respondent did housework, cared for his lawn, and that he had informed Dr. Silva that he was able to tolerate the pain with medication. MetLife informed Respondent that he could "request

a review of [his] claim" by sending a request to MetLife's "Group Claims Review." [L:144-145] Respondent retained an attorney who sent a letter to MetLife requesting review of the denial. [L:148-149]

Dr. Hartman referred Respondent to Dr. Williams. [L:55] There is no evidence on the record that Dr. Williams ever treated Respondent, but he did refer him to USC University Hospital for a CT scan and a discogram[4]. [L:49-52] The impression from the CT scan was, "Annular Thinning of the Intervertebral Discs at L4-5 and L5-S1, Loss of Disc Space at L4-5 and L5-S1". [L:51] The impression from the discogram was, "Concordant pain was demonstrated at L4-5 and L5-S1 following injection of the discs." [L:50]

Respondent's attorney secured "Physical Capacity Evaluations" from Dr. Hartman and Dr. Williams. [Excerpts from Clerk's Record BD 142; L:53, 83] Both evaluations are "check the box" type evaluations that have 33 questions with up to eight choices per question. Both evaluations are virtually identical. They both estimate that Respondent could sit for only one hour during a work day. Neither of the reports addresses Respondent's ability to perform his job of material planner either with accommodation, such as intermittent standing or walking, or mediation, including medication. There is no evidence in

[4] A discogram is a diagnostic procedure to determine which disc is the cause of pain. When an electrical charge was sent through a needle inserted into various parts of Respondent's spinal column, he was asked to report whether he felt a pain or not. Since lidocaine, an anesthetic, was used, the discogram could not have determined the level of pain that Respondent experiences in his work life. [L:49-50]

the record that any of Respondent's doctors ever evaluated his work capacity or looked at his job description.

The American Medical Association has published guides that establish criteria for the degree of pain suffered by a patient. *Guides to the Evaluation of Permanent Impairment,* American Medical Association 18.3f (Fifth Ed. 2002). [Brief App. 1][5] Respondent never submitted any medical opinions as to the level of pain that he suffered during his normal workday.

At Petitioner's request, Respondent was examined and evaluated by Dr. Antoine Mitri, a neurologist. Dr. Mitri's independent medical examination report, dated July 17, 1998, states that the examination was normal except for some limitation of bending. [L:43-48] Dr. Mitri's report notes that Respondent had "no limitation" with respect to transportation, standing, sitting, changing positions between standing and sitting, reaching forward and overhead, grasping or handling, finger dexterity, operating electrical equipment and concentrated visual attention. *Id.* Dr. Mitri noted "some limitation in assuming cramped or unusual positions, twisting, pushing or pulling, repetitive movements, and operating a truck or dolly." *Id.* Dr. Mitri's diagnosis was lumbrosacral degenerative disc disease and chronic myofascial pain syndrome. [L:45, 46] The report concludes that

> "[after] *reviewing the patient's job description,* and on the basis of the general examination

[5] The Appendix to Petitioner's Brief on the Merits, filed on February 24, 2003, is referred to hereafter as "Brief App." followed by the page number.

> and neurological examination, and after reviewing the report of his test, [MRI and the EMG] I think that the patient should be able to do sedentary work with some interruption by walking in between. Accordingly, *I do not think the patient is disabled to perform that kind of work* even though he is complaining from low back pain [because] all the work up that was done did not really show any evidence to substantiate disability in doing sedentary work with some walking interruption in between." [L:45] (emphasis added)

MetLife sent Dr. Mitri's report to Respondent. MetLife asked that Respondent submit Dr. Mitri's report to Respondent's treating physician and obtain his comment on it. [Petition App. 88] Respondent failed to provide his treating physician's response to Dr. Mitri's opinion. MetLife made a second request that he provide a response to Dr. Mitri's report from his treating physician. [Petition App. 87] Respondent never provided the requested comments from his treating physician. [L:156]

Respondent's attorney sent a set of hypothetical questions to Janmarie Forward, a human resources representative at Kwikset.[6] [L:33-37] An example of one of his hypothetical questions is:

> Dr. Mitri indicates that's [sic] Kenneth Nord can do sedentary capacity, as long as he can

[6] The Ninth Circuit opinion erroneously states that "Forward's opinion was solicited by the administrator." 296 F.3d at 830. This statement is not supported by the record. Respondent's counsel sent these questions directly to Ms. Forward. [Excerpts from Clerk's Record BD 132-37; L:33-37]

> interrupt his sitting by walking in between at will. In your employer statement provided to Metropolitan, you have described the job as requiring sitting between 5 and 6 hours in a day and standing and walking between 1 and 2 hours in a day. Assume that the need to stand and walk to relieve pain is unpredictable and that when the pain requires walking about, the individual must get up and move.
>
> **Could the individual with those limitations perform the work of a material planner?**
>
> **___yes___no**

Ms. Forward checked the response "yes." [L:36-37]

Ms. Forward responded "yes" that Respondent could perform the job of a material planner to all but the following question:

> Dr. Mitri describes Kenneth Nord as suffering from degenerative disc disease and a chronic myofascial pain syndrome. You have indicated in your employer statement provided to Metropolitan that the work of a material planner requires continuous interpersonal relationships and frequent exposure to stressful job situations. Assume that Kenneth Nord would have a moderate pain that would interfere with his ability to perform intense interpersonal communications or to act appropriately under stress occasionally (up to one-third) during the day.
>
> **Could individual [sic] of those limitations perform the work of a material planner?**
>
> **___yes___no**

Ms. Forward checked the response "no." *Id.*

The question is a hypothetical that is not based upon any medical evidence in the record. There is no medical evidence that Respondent suffered "moderate" pain; the only medical evidence is that he suffered some pain which was controlled by medication. [L:43-47, 49-52, 68, 85-94, 97-100, 102-103, 155-156]

After reviewing the reports, MetLife made a recommendation to the Plan Manager to uphold the denial of Respondent's claim and provided the Plan Manager with all of the information upon which it relied in coming to that conclusion. [L:42]

Prior to making his decision, the Plan Manager telephoned Ms. Forward and asked her about her response to the hypothetical question posed by Respondent's counsel as to whether Respondent could perform his job if moderate pain "interfere[d] with his ability to perform intense interpersonal communications or to act appropriately under stress." The Plan Manager questioned Ms. Forward about her response. He also asked Ms. Forward about the job of a material planner. Ms. Forward told him that it was a desk job and that Respondent was free to sit or stand at will and that help was available for lifting. [Petition App. 93]

Using his "sole and absolute discretion" to interpret the Plan and make a disability benefit determination based on "suitable medical evidence," the Plan Manager decided that Respondent's back pain was not so disabling that he was unable to perform his own job. The Plan Manager informed Respondent of his decision on October 27, 1998 and how he could appeal that decision under ERISA. [L:155-156]

D. The Litigation

Respondent filed suit in the Central District of California seeking benefits under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B). Petitioner and Respondent both filed motions for summary judgment. In considering both motions, the district court reviewed the denial of benefits for an abuse of discretion under the standard set forth in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989). [Petition App. 33] The district court found that Respondent had not sufficiently met his burden under prior Ninth Circuit precedent to invoke *de novo* review by providing material probative evidence tending to show that Petitioner's self-interest caused a breach of fiduciary duty. Respondent argued to the court that Janmarie Forward's answers to his hypothetical questions showed that he was disabled. The court stated it was within the Plan Manager's discretion to reject the opinion of an untrained person over the opinion of a medical examiner and that the question posed to Ms. Forward failed to deal with the effect of medication on Respondent's work behavior. [Petition App. 33-34] Respondent also argued the "treating physician rule." The court held it was within the Plan Manager's discretion whether to accept the opinion of a treating physician or the opinion of an examining expert. [Petition App. 35-36] The court pointed out that this was especially true where the Petitioner had provided two opportunities for Respondent's treating physicians to review and respond to the independent examining physician's report which they failed to do. [Petition App. 34-35] The district court upheld the denial of benefits as properly within the Petitioner's discretion, granted Petitioner's motion for summary judgment and denied Respondent's motion for summary judgment. [Petition App. 18]

Respondent appealed the judgment on Petitioner's Motion for Summary Judgment but did not appeal the denial of Respondent's Motion for Summary Judgment. [Excerpt from the Clerk's Record, No. 34] In considering the appeal, the Ninth Circuit relied on its ruling in *Regula v. Delta Family-Care Disability Survivorship Plan,* 266 F.3d 1130 (9th Cir. 2001), which requires application of a treating physician rule to ERISA governed disability plans. The Ninth Circuit agreed that Petitioner's Plan conferred discretion to determine eligibility for benefits on the Plan Manager. However, the court concluded that the Plan Manager had an actual conflict of interest which tainted his decision because (1) his rejection of the response of Janmarie Forward was "high handed" and evidence of a conflict of interest; and (2) the fact that the Plan Manager had not complied with the Ninth Circuit's treating physician rule was material probative evidence that the conflict of interest had tainted the Plan Manager's decision. Therefore, the Ninth Circuit held that the appropriate standard of review was *de novo*.

In its *de novo* review of the evidence, the court found the only evidence offered by Petitioner was the opinion of Dr. Mitri, a qualified neurologist. Despite the fact that Dr. Mitri had examined Respondent, physically tested him, reviewed his previous medical records and examinations and reviewed his job description, the court discounted Dr. Mitri's opinion. The court stated that Dr. Mitri's opinion was "a scintilla of evidence" that "does not present a genuine issue of material fact." *Nord,* 296 F.3d at 832.[7] The

[7] This finding is in conflict with prior Ninth Circuit SSA precedents. "Where the opinion of the claimant's treating physician is

(Continued on following page)

court found that Dr. Mitri's opinion was overwhelmed by substantial evidence in the record, including "the opinions of three treating physicians that Nord's condition rendered him unable to meet the physical requirements of his position as a Material Planner."[8] *Id.* The court set aside the decision of the district court on Petitioner's Motion for Summary Judgment. Instead of remanding the case to the district court for further proceedings, the court *sua sponte* entered judgment for Respondent on the basis that "no reasonable person could conclude that Respondent was not disabled." *Id.*

SUMMARY OF ARGUMENT

The Ninth Circuit's treating physician rule is inconsistent with ERISA's goals of not discouraging employers from adopting disability benefit plans and increasing the benefits of ERISA disability benefit plans. The Ninth Circuit's treating physician rule imposes an unduly heavy burden on lay plan administrators to rebut a treating physician's opinion by providing specific, legitimate

contradicted, and the opinion of a nontreating source is based on independent clinical findings that differ from those of the treating physician, the opinion of the nontreating source may itself be substantial evidence; it is then solely the province of the ALJ to resolve the conflict." *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995).

[8] There is no evidence in the record at all that three treating physicians opined that Respondent was "unable to meet the physical requirements of his position as a Material Planner." Dr. Hartman provided his diagnosis and an estimate of his physical capacity. [L:57, 81, 84] Dr. Williams only provided an estimate of his physical capacity. [L:83] Dr. Silva provided no opinion at all.

reasons for rejecting the opinion based on substantial evidence or in some cases clear and convincing evidence in the record. The rule ignores the fiduciary obligations already placed on plan administrators by ERISA. Placing this legal standard on plan administrators forces them to hire expensive medical experts and to engage legal counsel to review their benefit denials. In addition, the rule encourages litigation by claimants.

The Ninth Circuit's treating physician rule infringes on and conflicts with the authority given to the Department of Labor ("DOL") to ensure that disability benefit plans provide a reasonable opportunity for a full and fair review by the plan administrator of a denial of benefits. The DOL in its regulations has never imposed a treating physician rule on plan administrators. Instead, the DOL has attempted to "preserve the greatest flexibility possible for designing and operating claims processing systems consistent with prudent administration of the plan." The Ninth Circuit's treating physician rule interferes with that flexibility and infringes on the administrator's discretion.

The Ninth Circuit's treating physician rule is based upon a false assumption that the treating physician is the most responsible and credible physician in regard to a claimant's disability. The rule fails on its face because it does not take into account the quality of the treating physician's opinion, the length of time she has treated the patient, her experience with similar impairments and her training. In addition, the rule assumes that treating physicians will provide objective diagnoses of their patient's disability. Yet, due to of the shift in medical decision making from independent physicians to managed care institutions, treating physicians have become advocates for their patients in obtaining insurance benefits. A large

number of treating physicians admit that they make false diagnoses and reports to help patients obtain insurance payments. A treating physician may or may not be the most responsible or knowledgeable medical professional regarding a patient's disability. For example, many treating physicians have little or no experience or training in regard to back pain. However, a consulting neurologist may have treated thousands of similar cases. There is no legitimate reason to have a blanket rule giving the opinions of treating physicians preference over other physicians' opinions.

The Ninth Circuit treating physician rule shifts the burden from a claimant to prove that the plan administrator's decision was an abuse of discretion to the plan administrator to show specific legitimate reasons for rejecting the treating physician's opinion based upon substantial evidence or, in some cases, clear and convincing evidence in the record. The rule is contrary to this Court's holding in *Firestone* that the plan administrator's decision should be reviewed for abuse of discretion in all cases where, like here, the plan administrator has discretion to make benefit decisions. The Ninth Circuit treating physician rule conflicts with the abuse of discretion test when it is used to determine (1) whether an actual conflict of interest tainted the plan administrator's decision and (2) the reasonableness of the plan administrator's decision in a *de novo* review. The rule places an unreasonable and costly burden on plan administrators. It is contrary to this Court's prior opinions and should be rejected by this Court.

ARGUMENT

THE TREATING PHYSICIAN RULE IS INCONSISTENT WITH ERISA'S GOAL OF NOT UNDULY DISCOURAGING EMPLOYERS FROM OFFERING DISABILITY PLANS

This Court held in *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996), that one of the Congressional concerns in drafting ERISA was " . . . not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans. . . . " In determining whether to impose restrictions on the decisions of ERISA plan administrators, this Court has balanced carefully the burden of the restriction against the public benefit in encouraging the formation of employment disability plans. *Pilot Life v. Dedeaux*, 481 U.S. 41, 54 (1987). The Ninth Circuit treating physician rule disrupts that balance by imposing a legalistic standard on plan administrators which will have the effect of increasing plan administration, medical expenses and legal costs. The Ninth Circuit treating physician rule discourages, rather than encourages, employers to adopt ERISA disability plans.

A. Plan Administrators Are Fiduciaries

Congress created ERISA knowing that employers would appoint employee plan administrators who are fiduciaries and beneficiaries of plans, as well as managers of the company.

> "Under ERISA, however, a fiduciary may have financial interests adverse to beneficiaries. Employers, for example, can be ERISA fiduciaries and still take actions to the disadvantage of

> employee beneficiaries, when they act as employers (*e.g.*, firing a beneficiary for reasons unrelated to the ERISA plan), or even as plan sponsors (*e.g.*, modifying the terms of a plan as allowed by ERISA to provide less generous benefits)." *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000).

Employers are not required to offer ERISA plans or particular plan benefits. *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). One of ERISA's tradeoffs to encourage employers to offer ERISA benefit plans is to allow employers to appoint employee plan administrators who are both fiduciaries and beneficiaries, as well as managers. The Ninth Circuit treating physician rule assumes that plan administrators who do not rebut treating physician's opinions are not providing fellow employees their rightful plan benefits. The rule ignores the fact that plan administrators are also beneficiaries of the plan, as well as fiduciaries who have legal obligations to the plan members:

> "The most fundamental duty owed by the trustee to the beneficiaries of the trust is the duty of loyalty. . . . It is the duty of a trustee to administer the trust solely in the interest of the beneficiaries." 2A A. Scott & W. Fratcher, Trusts § 170, 311 (4th ed. 1987).
>
> . . . .
>
> "The statute provides that fiduciaries shall discharge their duties with respect to a plan 'solely in the interest of the participants and beneficiaries,' § 1104(a)(1), that is, 'for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan,' § 1104(a)(1)(A)."

Pegram, 530 U.S. at 223-24. Plan administrators must discharge their duties:

> "(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;
>
> . . . .
>
> "(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV."

29 U.S.C. § 1104(a)(1).

When Congress placed fiduciary obligations in the law, it assumed the plan administrators would heed those obligations. If Congress had not made that assumption, it would not have permitted companies to appoint employee administrators. For those few plan administrators who ignore their fiduciary obligations, it placed personal liability in the law. 29 U.S.C. § 1109(a). The Ninth Circuit's decision assumes that employee plan administrators will ignore the requirements of ERISA and will violate the law. There is no fact or reason on which to base such an assumption and this Court should strike down the Ninth Circuit treating physician rule.

B. The Ninth Circuit's Treating Physician Rule For ERISA Cases

The Ninth Circuit's treating physician rule as applied in *Regula* and *Nord* is:

> If the treating physician's opinions are uncontroverted, the plan administrator may reject the treating physician's opinions only by providing "specific, legitimate reasons" which must be "clear and convincing" and "based on substantial evidence in the record." *Regula*, 266 F.3d at 1140 (quoting *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999) and *Smolen v. Chater*, 80 F.3d 1273, 1285 (9th Cir. 1996)).
>
> If the treating physician's opinions are controverted, the plan administrator may reject the treating physician's opinions only by giving "specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Nord*, 296 F.3d at 831 (quoting *Morgan*, 169 F.3d at 600).

C. The SSA Treating Physician Rule

The treating physician rule first appeared in a Second Circuit Court of Appeals case in 1972 involving disability determinations by administrative law judges ("ALJ's") under the Social Security Act. *Gold v. Secretary of Health, Education and Welfare*, 463 F.2d 38, 42-43 (2d Cir. 1972). Under intense pressure from the Second Circuit, the Social Security Administration ("SSA") adopted regulations in 1991 requiring ALJs to apply the treating physician rule. 20 C.F.R. § 404.1527(d); *see Schisler v. Sullivan*, 3 F.3d 563, 565-569 (2d Cir. 1993) *See* Pierce, *Administrative Law Treatise* § 11.3. However, even while the Second Circuit requires the SSA to apply its treating physician rule, the Second Circuit has held that the treating physician rule

does not apply in ERISA cases. *Conners v. Connecticut General Life Ins. Co.*, 272 F.3d 127, 135 n.4 (2d Cir 2001).

D. The Ninth Circuit Does Not Follow The Treating Physician Rule In The SSA Regulations

In this case and in *Regula*, the Ninth Circuit referenced the treating physician rule used by the SSA and codified at 20 C.F.R. §§ 404.1527(d), 416.927(d) (2001). However, the Ninth Circuit does not follow the SSA rule, even in SSA cases. The Ninth Circuit applies its own version of the treating physician rule in cases brought under the Social Security Act. *Magallanes v. Bowen*, 881 F.2d 747, 750 (9th Cir. 1989); *Lester v. Chater*, 81 F.3d 821, 831-32 (9th Cir. 1995); and *Morgan v. Commissioner of the SSA*, 169 F.3d 595, 600, 601 (9th Cir. 1999). The Ninth Circuit in *Regula* and *Nord* adopted this judicially created version of the treating physician rule into the ERISA context. *See* Pierce, *Administrative Law Treatise* § 11.3.

E. The SSA Disability Rule Has Been Rejected By The Courts In Other Disability Determinations

The treating physician rule has been rejected by the courts for disability determinations in other contexts. The SSA treating physician rule has been rejected for veterans' disability benefit determinations. *White v. Principi*, 243 F.3d 1378 (Fed. Cir 2001). In addition, the courts have rejected the treating physician rule in black lung disability determinations. *See, e.g., Peabody Coal Co. v. Helms*, 901 F.2d 571, 573 (7th Cir. 1990). "[I]t is irrational to prefer the opinion of the treating physician, who is often not a specialist, over the opinion of a nontreating specialist *solely* because one physician is the treating physician."

Peabody Coal Co. v. Director, Office of Workers' Compensation Programs, 972 F.2d 178, 182 (7th Cir. 1992) (emphasis added); *Consolidated Coal Co. v. Held*, 314 F.3d 184 (6th Cir. 2002); *but see Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3154 (Aug. 17, 2002) (*U.S. no. 02-249*), *petition for reh'g pending*.

In addition, the Courts of Appeal for the First, Second, Fourth, Seventh and Eleventh Circuits have all rejected the SSA treating physician rule in ERISA cases.[9]

F. ERISA Disability Claims Are Different Than SSA Claims

In *Regula*, the Ninth Circuit held, "[t]herefore, for reasons having to do with common sense as well as consistency in our review of disability determinations where benefits are protected by federal law, we see no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions." *Regula*, 266 F.3d at 1139. However a formal adjudicative decision by a trained administrative law judge applying specific regulatory criteria is entirely different than a decision by a lay ERISA plan administrator applying plan language. As stated in the dissent in *Regula*:

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[9] *Leahy v. Raytheon Company*, 315 F.3d 11 (1st Cir. 2002) (unanimous opinion declining to adopt Ninth Circuit's treating physician rule joined by Fletcher, J., the author of *Nord* and *Regula*); *Conners v. Connecticut General Life Ins. Co.*, 272 F.3d 127, 135 n.4 (2d Cir 2001); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-8 (4th Cir 1999); *Wilczynski v. Kemper Nat'l. Ins. Co.* 178 F.3d 933, 938 (7th Cir. 1999); *Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002).

" . . . [T]here are significant differences between Social Security and ERISA that counsel against adoption of the rule in the ERISA arena. [¶] Congress and the Social Security Administration ('SSA') have created an elaborate statutory and regulatory scheme governing Social Security disability determinations. *See* 42 U.S.C. §§ 401-433; 20 C.F.R. §§ 404.1-.2127, 416.101-.2227. For instance, the SSA has created a detailed five-step procedure to evaluate which claimants are disabled and therefore entitled to Disability Insurance benefits. *See* 20 C.F.R. § 404.1520, 416.920; *see also Cleveland v. Policy Mgmt. Sys. Corp.*, 526 U.S. 795, 804 (1999) (describing the SSA's five-step evaluation process). As part of this sequential procedure, the SSA has created grids to provide guidance about whether a claimant is disabled. *See* 20 C.F.R. § 404, Subpart P, Appendix 1-2; *Reddick v. Chater*, 157 F.3d 715, 729 (9th Cir. 1998). The SSA has also codified the treating physician rule in the regulations governing disability determinations. *See* 20 C.F.R. §§ 404.1527(d); 416.927(d). Thus, although this Court reviews Social Security benefits eligibility determinations made by an Administrative Law Judge ("ALJ") for substantial evidence an application of the correct legal standards (similar to the ERISA context), see *Flaten v. Sec'y of Health & Human Servs.*, 44 F.3d 1453, 1457 (9th Cir. 1995), an ALJ must follow far stricter guidelines (such as detailed grids) than a plan administrator making the same determination under ERISA."

Id., at 1150 (Brunetti, J. dissenting).

In addition, as in this case, a decision by a plan administrator that an employee is disabled from *his own occupation* is entirely different than an ALJ's decision in an SSA case that a person is disabled from "any substantial gainful activity." 20 C.F.R. § 416.927(a)(1). First, the burden is ultimately on the SSA, and not on the claimant, to prove that the claimant is not totally disabled from any substantial gainful activity. *Bowen v. Yuckert*, 482 U.S. 137, 146, n. 5 (1987). Therefore, the treating physician rule in SSA does not shift the burden from the claimant to the ALJ. However, as applied by the Ninth Circuit in ERISA cases, the treating physician rule shifts the burden to the plan administrator to provide specific, legitimate reasons for rejecting the treating physician's opinion. Secondly, a determination that a person is disabled from his own occupation requires knowledge and information about that occupation. In this case, the plan administrator had to know the requirements of the job of material planner. A decision that a person is disabled from any substantial gainful activity does not require any knowledge of any specific job.

Finally, the Ninth Circuit treating physician rule is applied differently in SSA cases than in ERISA cases. In an SSA case, the Ninth Circuit treating physician rule is applied to determine whether the ALJ's opinion is supported by substantial evidence. In ERISA cases, the Ninth Circuit uses the treating physician rule: (1) to determine whether the plan administrator's denial of benefits is tainted by an actual conflict of interest, requires courts in the Ninth Circuit to apply *de novo* review; and (2) to test the reasonableness of the plan administrator's decision.

G. Imposing The Ninth Circuit's Treating Physician Rule On Plan Administrators Reduces The Administrator's Discretion And Discourages Employers From Adopting ERISA Plans And Improving Benefits

This Court has held that courts should not interfere with the contractual terms agreed upon by an employee and employer in forming an ERISA plan. *See, e.g., Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Where the plan requires a deferential abuse of discretion standard of review, and when reasonable minds could differ over the medical evidence in the record, then the administrator decides. *Consolidated Edis n Co. v. NLRB,* 305 U.S. 197, 217 (1938). The Ninth Circuit treating physician rule requires a lay plan administrator to satisfy a court that she has rebutted the opinion of a treating physician for specific reasons that are based on substantial evidence, or in some circumstances clear and convincing evidence, in the record. Forcing lay plan administrators to rebut the treating physician rather than to evaluate the entire medical record conflicts with plans, such as this one, which provide for deferential review. It also conflicts with ERISA's goals of simplicity and ease of administration. *See Gallo v. Amoco Corp.*, 102 F.3d 918, 922 (7th Cir. 1996) (holding it is error for court to require "that plan administrator articulate the grounds for the interpretation in the course of reviewing an adverse determination on a claim for benefits, as if the plan administrator were an administrative agency. There is no such requirement in the law.")

"Employers do not have to provide employee disability plans. Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what

kind of benefits employers must provide if they choose to have such a plan." *Lockheed,* 517 U.S. at 887. The *Regula* treating physician rule takes away employer discretion and forces employers to pay disability benefits even when their plan administrators have an honest and good faith belief that the claimant is malingering. Employers without disability plans have no incentive to adopt a disability plan with burdensome procedures that encourage court litigation and require plan administrators to hire expensive medical and work capacity experts.

Forcing the Ninth Circuit's treating physician rule onto ERISA plan administrators is counterproductive to one of the basic purposes of ERISA – to encourage employers to adopt disability plans and to increase benefits to current plans. This Court should decline to adopt such a rule as part of the federal common law.

THE NINTH CIRCUIT'S TREATING PHYSICIAN RULE INFRINGES ON AND CONFLICTS WITH THE AUTHORITY DELEGATED BY CONGRESS IN ERISA TO THE DEPARTMENT OF LABOR

The treating physician rule infringes on the specific delegation of authority by Congress to the DOL to ensure that a benefit plan affords a "reasonable opportunity" for a "full and fair review" by a plan fiduciary of a decision denying a claim for benefits.[10] The DOL has exercised this

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[10] "In accordance with regulations of the Secretary, every employee benefit plan shall ... (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2).

Congressionally-delegated authority and adopted regulations providing standards that are incumbent in a "full and fair" review process. The DOL has never required plan administrators or fiduciaries to adopt the treating physician rule. Indeed, in its most recent revisions to the "full and fair" review rules, the DOL regulatory scheme mandates that before the plan fiduciary reaches a decision, it should consider evidence from the claimant (presumably in the form of a treating physician opinion) *and* consult with an independent health care professional with appropriate training and experience in the relevant field of medicine. *See* 29 C.F.R. §§ 2560.503-1(h)(2)(ii); (h)(3)(iii), (v); (h)(4).[11] In its guidance regarding these rules, the DOL has stated that they were written to provide a balance between plan flexibility and enrollee confidence in disability plans and efficiency in the disability insurance and labor markets. The DOL has written its ERISA regulations " . . . to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with prudent administration of the plan." *U.S. Department of Labor, Pensions and Welfare Benefits Administration,* www.dol.gov/pwba [Petition App. 52-53]

Congress expressly gave the DOL authority to regulate the procedures a plan administrator must follow in order to afford a reasonable opportunity for a full and fair review of a denial of claim benefits. The DOL's revised regulations have never imposed a treating physician rule. When the DOL adopts a regulation affecting procedures

[11] These rules became effective January 1, 2002, and therefore do not directly affect this case.

for ERISA plan administrators, it first studies the problem, publishes its proposed regulation for comment and accepts public comments on the proposed regulation. In this case, the Ninth Circuit reached out to an unrelated area of law and selected a rule to impose on ERISA plan administrators which is based upon a false assumption and is counterproductive to the purposes of ERISA. This Court should overturn the imposition of the Ninth Circuit's treating physician rule on ERISA plan administrators.

THE NINTH CIRCUIT'S TREATING PHYSICIAN RULE IS GROUNDED ON A FALLACIOUS ASSUMPTION THAT A DOCTOR CHOSEN BY AN EMPLOYEE FOR TREATMENT IS INHERENTLY MORE RESPONSIBLE AND MORE COMPETENT THAN AN EXAMINING OR REVIEWING SPECIALIST

In *Regula*, the Ninth Circuit concluded that:

> "The treating physician rule applied in the Social Security setting requires that the administrative law judge ('ALJ') determining the claimant's eligibility for benefits give deference to the opinions of the claimant's treating physician, because 'he is employed to cure and has a greater opportunity to know and observe the patient as an individual.' [citations omitted] This grant of deference to a treating physician's opinions increases the accuracy of disability determinations, by forcing the ALJ who rejects those opinions to come forward with specific reasons for his decision, based on substantial evidence in the record."

266 F.3d at 1139.

There is no empirical evidence that supports this statement.[12] The statement is an erroneous stereotype that does not reflect the current practice of medicine.

The Ninth Circuit's treating physician rule fails on its face because it does not address the quality of the treating physician, the length of treatment, or the experience and training, if any, of the treating physician in the type of disability the patient is claiming. There is no definition in the Ninth Circuit's treating physician rule of the term "treating physician." Under the rule, the opinion of a physician who has "treated" a patient one time is afforded the same weight as that of a physician who has been treating the patient through the entire course of his impairment. In addition, the rule assumes that there is only one treating physician's opinion. However, in many

[12] In fact the treating physician rule has been criticized even in the SSA context:

> "The courts have also frustrated the achievement of accuracy in SSA disability evaluations by forcing SSA and its ALJs to give weight to unreliable evidence at the expense of reliable evidence. According to the 'treating physician rule' – a judicially created exception to the deferential substantial evidence test – SSA and its ALJs must give greater weight to the opinions of applicants' treating physicians than to the opinions of consulting physicians. *See, e.g., Stieberger v. Bowen,* 801 F.2d 29, 31 (2d Cir. 1986). *See* § 11.3. The exception is premised on the courts' belief that treating physicians' opinions are more reliable than consulting physicians' opinions – a belief that the courts are alone in holding. Congress, SSA, ALJs, and independent investigators agree that 'as a matter of both bias and degree of qualification the consulting physician is likely to be much the better information source.' J. Mashaw, et al., Social Security Hearings at 57."

Pierce, *Administrative Law Treatise* § 9.10.

cases there are disputes between two or more treating physicians as to the extent of disability. When there are two dueling treating physicians, the Ninth Circuit's treating physician rule places the burden on the plan administrator to reject one of the opinions based on specific, legitimate reasons based on substantial evidence in the record, regardless of the fact that he accepted another treating physician's opinion.

Surveys conducted by doctors for doctors show that in today's medical environment treating physician's opinions are not the most responsible in regard to a patient's disability because, among other reasons: 1) the treating physician may be accommodating her patients to obtain insurance payments for them, and 2) the treating physician may lack experience and training in regard to the impairment that she is evaluating.

A. Treating Physicians Often Accommodate Their Patients To Obtain Insurance Payments For Them

Within the past fifteen years the medical world has changed dramatically. The image of the general practitioner who has a long-term relationship with each of his patients and who diagnoses and treats all of their ills has given way to managed care facilities and HMOs where patient care is determined by medical administrators, where a patient may never see the same doctor twice and where specialists are brought in for one time testing and evaluation of patients. "With amazing speed, American medicine is evolving in uncharted directions. Managed care has transformed a 'cottage industry' run by highly individualistic physicians into a far more controlled enterprise in which many other players wield major

influence, both financial and professional." Alper, Philip R., M.D., *The Doctor-Patient Breakdown: Trouble At The Core Of The Medical Economy,* Heritage Foundation, Policy Review April 1, 2002. [Brief App. 157] The Seventh Circuit recognized this shift in the medical profession in *Peabody Coal Co. v. McCandless,* 255 F.3d 465, 469 (7th Cir. 2001) "[t]reating physicians often succumb to the temptation to accommodate their patients ... at the expense of third parties such as insurers, which implies attaching a discount rather than a preference to their views."

Treating physicians report that they frequently accommodate their patients by not accurately reporting their diagnoses to obtain insurance payments for their patients.[13] In a survey of doctors by doctors, 78% of treating physicians reported that they would deceive an insurance company to obtain insurance payments for a patient. Novack, et al., *Physician Attitudes Towards Using Deception To Resolve Different Ethical Problems* 261 J. Am. Med. Assn. 2980 (1989). [Brief App. 94] In another survey of doctors, 64.3% of the treating physicians reported that it is necessary to manipulate insurance plan rules to obtain insurance payments, including exaggerating the severity of the patient's condition. Wynia, *Physician Manipulation of Reimbursement Rules for Patients* 283 J. Am. Med. Ass'n 1858 (April 12, 2000). [Brief App. 23] In addition, 39% of

[13] This practice is so widespread that the health care industry has adopted a euphemism for the practice – "gaming the system." *See Gaming the System: Dodging the Rules, Ruling the Dodgers,* 151 Archives, Int. Med. 443-447 (1999) [Brief App. 135]; Wynia, *Physician Manipulation of Reimbursement Rules for Patients* 283 J. Am. Med. Ass'n 1858 (April 12, 2000). [Brief App. 23]

those treating physicians surveyed reported that within the past year they had 1) exaggerated the severity of a patient's condition, or 2) changed the patient's billing diagnosis, or 3) reported signs or symptoms that the patient did not have in order to help the patient secure payments from insurers. *Id.* Of the physicians surveyed, 28.5% agreed with the statement, "[t]oday it is *necessary* to game the system to provide high quality care" and 15.3% agreed that it is also *ethical* to do so. *Id.* In a poll by the Association of American Physicians and Surgeons, Inc., 87% of the treating physicians reported that they purposefully kept medical information out of their patients' records. *Guarding Medical Secrets, At A Cost,* U.S. News and World Report, August 13, 2001. [Brief App. 122] In another survey of doctors by doctors, 57.7% of the treating physicians reported that they would give a false diagnosis to obtain insurance payments for a patient. Freeman, *Lying for Patients – Physician Deception of Third-Party Payers,* 159 Archives of Internal Med. 2263 (October 25, 1999). [Brief App. 61]

The DOL has recognized that a treating physician is not an unbiased decision maker, but rather is a "representative of the claimant." 63 Fed. Reg. 48390, 48392 (Notice of Proposed Rulemaking Sept. 9, 1998) ("it is the Department's view that an individual's attending physician would generally be treated as a representative of the claimant.") This is, in part, based on the DOL's perception that within the managed care context the separation between medical decision making and coverage determinations has been substantially eroded. *Id.* at 48391. The American Medical Association also sees the treating physician as an advocate, "[p]hysicians should advocate for patients in dealing with third parties when

appropriate." *Fundamental Elements of the Patient-Physician Relationship,* American Medical Association, http://www.ama-assn.org/ama/pub/category/2510.html (February 15, 2003) [Brief App. 123]

A treating physician needs to build a rapport with her patients, first to cure them, and second to keep them as patients. "The patient's regular physician may want to do a favor for a friend and client, and so the treating physician may too quickly find disability." *Stephens v. Heckler,* 766 F.2d 284, 289 (7th Cir. 1985). If the treating physician reports symptoms which do not exist to obtain insurance payments, declares a malingering patient disabled from work or performs requested but unnecessary tests to obtain additional insurance benefits for her patient, she builds patient rapport and goodwill. If the patient reports subjective pain, inability to function or psychological problems, the treating physician will lose patient rapport if she challenges the statements and build patient goodwill and trust if she accepts the patient's statements as true.

> "When psychological testimony is used to establish the presence of psychological injury, the circumstances are very different. In virtually every case, the patient presents his or her history and symptoms to the therapist, who generally accepts the account at face value. *No attempt is made to test or disconfirm the implicit hypothesis that the patient's account of events is accurate.* The basis of successful psychotherapy is a trusting relationship between therapist and client. Since any attempt by a therapist to verify or disconfirm the patient's version of events would probably destroy this trust, *treating therapists rarely attempt to assess the possibility of false imputation or malingering.*"

Eric G. Mart, *Psychotherapist Testimony to Personal Injury Cases: Coping with The Stealth Evaluation*. Massachusetts Bar Association Lawyers Journal (March 1997) (emphasis added). [Brief App. 53]

The treating physician rule assumes that doctors are providing objective, unbiased opinions regarding patient disability. However, that assumption is not supported by the medical profession's own surveys of treating physicians. The Ninth Circuit's treating physician rule is based upon an outdated stereotype of treating physicians. It has no place in today's medical managed care marketplace.

B. The Treating Physician May Have Misdiagnosed The Patient Through Inexperience Or Lack Of Training

The Ninth Circuit's treating physician rule assumes that the patient has selected a responsible, competent physician, who has provided a correct diagnosis. The patient, however, may have selected a physician who has never treated or observed a similar infirmity.[14] "The regular physician also may lack an appreciation of how one case compares with other related cases. A consulting physician may bring both impartiality and expertise." *Stephens,* 766 F.2d at 289. There is nothing inherently

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[14] An example of this was pointed out in *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002). "While Moran's primary care physician acknowledged petitioner's affiliated surgeons had not recommended the unconventional surgery and that he was not 'an expert in this or any other area of surgery' . . . [n]onetheless he opined, without explanation, that Moran would be 'best served' by having that surgery." 536 U.S. at 405 (Thomas, J., dissenting).

reliable about a patient's selection of a treating physician. She may have selected her physician because the office was convenient, the physician was recommended by a friend, or the physician treated her for other unrelated complaints. The inexperience of the patient in selecting the doctor may result in the selection of a doctor who is inexperienced or incompetent. As stated by the Nevada Supreme Court in *McClanahan v. Raley's, Inc.*, 34 P.3d 573, 577 (Supreme Court of Nevada 2001):

> "Nevertheless, we question the premises upon which the treating physician rule rests. We do not agree that because a physician has a duty to cure a patient that the physician will necessarily be more familiar with an issue such as the cause of an injury. An ability to reliably identify the cause of an injury may be less a product of familiarity with a patient and more the product of specialized skill, training and experience. We recognize that physicians commonly rely not solely upon their own observations but upon the expertise of other physicians with particular specialties when trying to resolve questions such as diagnosis of a condition and causation of an injury. Under these circumstances physicians may send the patient's records to another physician for review or the patient may be referred by the treating physician to be examined by a specialist. Additionally, a treating physician will not necessarily have spent more time with a patient than a physician who has been consulted for a second opinion. Even if a treating physician has spent more time with the patient, we do not view the quantity of time spent as a reason to give greater weight to that physician's opinion. The medical issue may be too complicated to resolve based solely upon the treating physician rule's supposition that the treating physician has spent more time with the patient than any other doctor. It is for these reasons that we reject the treating physician rule and determine that it has no applicability in this state."

Many treating physicians are inexperienced and untrained in providing work capacity evaluations. Even a qualified doctor may be unable to distinguish between medical impairment and disability from a particular occupation.

> "[M]edical impairments are not related to disability in a linear fashion. An individual with a medical impairment can have no disability for some occupations, yet be very disabled for others. For example, severe degenerative disk disease may impair the functioning of the spine of both a licensed practical nurse and a bank president in a similar fashion when performing their activities of daily living. However, in terms of occupation, the bank president is less likely to be disabled by this impairment than the licensed practical nurse."

Guides to the Evaluation of Permanent Impairment, American Medical Association 1.2b (Fifth Ed. 2002). [Brief App. 1]

In this case, Dr. Hartman's opinion reported Respondent's level of impairment. Dr Hartman reported that Respondent suffered from "lumbar disk syndrome." [L:66, 81, 84] He also reported Respondent's subjective complaints of pain. There is no evidence in the record which indicates in any way that Dr. Hartman knew the essential functions of the position of a material planner or considered work accommodations which could be provided to

Respondent. By focusing only on Respondent's impairment, he missed the critical elements of a work disability determination.

Dr. Hartman and Dr. Williams checked the boxes on a Physical Capacity Evaluation. However, while they reported on Respondent's ability to perform certain physical functions, they did not report on Respondent's work capacity for the job of material planner. Some persons with limited physical capacity outperform persons with no limitations; there is no direct relationship between a person's physical capacity and a person's work capacity.

> "[T]he impairment evaluation, however, is only one aspect of disability determination. A disability determination also includes information about the individual's skills, education, job history, adaptability, age, and environment requirements and modifications. Assessing these factors can provide a more realistic picture of the effects of the impairment on the ability to perform complex work and social activities. If adaptations can be made to the environment, the individual may not be disabled from performing that activity." *Guides to the Evaluation of Permanent Impairment* 1.2b (Fifth Ed. 2002). [Brief App. 1]

This Court has recognized that

> "[a]n individualized assessment of the effect of an impairment is particularly necessary when the impairment is one whose symptoms vary widely from person to person. Carpal tunnel syndrome, one of respondent's impairments, is just such a condition. While cases of severe carpal tunnel syndrome are characterized by muscle atrophy and extreme sensory deficits, mild cases generally do not have either of these effects and create only intermittent symptoms of numbness and tingling."

Toyota Motor Mfg., KY, Inc. v. Williams, 534 U.S. 184, 199 (2002). It would be ironic, indeed, if this Court were to hold that an employer must provide disability payments to an employee who the employer believes can work with the use of corrective measures and workplace accommodations, when at the same time, the employer is required by federal disability law to provide accommodations and consider corrective measures for individuals with a disability so they can work.

Over 75% of the American population will have low back pain at some time during their life. *Accommodating Individuals with Back Impairments* U.S. Department of Labor http://www.jan.wvu.edu (February 17, 2003). [Brief App. 125] For many people, it clears up within weeks. For others, they suffer pain but continue to perform their occupations using medication, therapy and avoidance of strain on their backs. There is no direct correlation between back injury and workplace disability. Each case must be evaluated individually. *Id.* The Respondent's physicians in this case only considered Respondent's impairment. There is no evidence on the record in this case that any of them went the next step and investigated whether Respondent could perform his job with accommodations and corrective measures, including pain relieving medication.

Dr. Mitri, the examining neurologist, diagnosed Respondent's impairment as lumbrosacral degenerative disc disease and chronic myofascial pain syndrome. [L:44-45] However, after diagnosing Respondent's condition, Dr.

Mitri looked at Respondent's job description and considered whether he could perform the work of a material planner. He determined that Respondent could perform his normal occupation if he was permitted to stand up and walk periodically. [L:43-45]

The Plan Manager who made the final decision denying benefits had available to him the requirements of the job of material planner, the reports of all of the medical doctors involved, the response of Janmarie Forward, his interview with Janmarie Forward and the Plan definition of disability. The Plan Manager had the information necessary to make the decision as to whether or not Respondent's impairment constituted a disability under the Plan. His decision was within the bounds of his discretion and should have been upheld. There is no legitimate reason in this case why the Plan Manager should have the burden of proving that the treating physician's opinion as to Respondent's impairment was wrong. This Court should reject the Ninth Circuit's treating physician rule in ERISA cases.

THE NINTH CIRCUIT'S TREATING PHYSICIAN RULE CONFLICTS WITH THIS COURT'S DECISION IN *FIRESTONE* BY SHIFTING THE BURDEN FROM THE CLAIMANT TO SHOW THAT THE PLAN ADMINISTRATOR'S DECISION CONSTITUTED AN ABUSE OF DISCRETION TO THE PLAN ADMINISTRATOR TO DEMONSTRATE THAT THE TREATING PHYSICIAN'S OPINION WAS WRONG

ERISA itself does not designate burdens regarding the determination of eligibility for disability benefits. ERISA merely requires plans to afford a beneficiary a "reasonable opportunity" for a "full and fair" internal review of a

benefit denial and "provides a right for a subsequent judicial forum for a claim to recover benefits." *Rush Prudential HMO v. Moran,* 536 U.S. 355, 401 (2002); 29 U.S.C. §§ 1132(a)(1)(B), 1133(2).

Federal common law requires that the beneficiary of an ERISA disability plan bear the burden of proving that he is entitled to a benefit under 29 U.S.C. § 1132(a)(1)(B). *Horton v. Reliance Standard Life Ins. Co.,* 141 F.3d 1038, 1040 (11th Cir. 1998); *Fuja v. Benefit Trust Life Ins. Co.* 18 F.3d 1405, 1408 (7th Cir. 1994).

A. The Treating Physician Rule Is Inconsistent With An Abuse Of Discretion Standard Of Review

In *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 115, this Court held that a court must look to the language of the plan to determine the standard of review in any action brought under 29 U.S.C. § 1132(a)(1)(B) challenging a denial of benefits. In cases such as this one where the language of the plan grants the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan, the standard of review is abuse of discretion, regardless of whether or not the plan administrator is operating under an actual or potential conflict of interest. *Id.*

In reaching that conclusion, this Court reasoned that it "need not distinguish between types of plans or focus on the motivations of plan administrators and fiduciaries."

Id.[15] Rather, the abuse of discretion standard of review applies regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest. *Id.* However, the potential or actual conflict of interest is not entirely irrelevant: "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'" *Id.*, quoting Restatement (Second) of Trusts § 187, Comment d (1959).

In this case, the Ninth Circuit used its treating physician rule from *Regula* first to determine that the plan administrator had an actual conflict of interest that tainted his decision and therefore mandated a *de novo* review by the court. *Nord*, 296 F.3d at 830-1; *Regula*, 266

[15] In *Firestone*, this Court rejected the Third Circuit's rationale that where an employer is itself the fiduciary and administrator of the plan, the plan's decision to deny benefits should be subject to *de novo* review because deference is unwarranted, given the lack of assurance of impartiality on the part of the employer. *Firestone*, 489 U.S. at 107-08, 115. The Ninth Circuit in this case used this same rejected logic to reach *de novo* review. That is, applying the treating physician rule, the Ninth Circuit concluded that Petitioner had an actual conflict of interest due to the fact that it rejected Respondent's treating physicians' reports and accepted the opinion of Dr. Mitri, without, in the Ninth Circuit's view, providing specific, legitimate reasons for doing so based on substantial evidence in the record. This conflict of interest voided the administrator's decision, subjecting it to *de novo* review. Yet, after this Court's opinion in *Firestone*, the Ninth Circuit's conflict of interest reasoning has no place in determining the standard of review. *Cf. Gallo*, 102 F.3d at 921-2 (holding that the question of the extent to which employers can be trusted to administer their own ERISA plans fairly is not an open question; where plan administrators have been given discretion, after *Firestone*, review is under abuse of discretion standard).

F.3d at 1147. ("[W]e add deviation from the treating physician rule to the short list of factors by which a court may determine that an apparent conflict of interest has ripened into an actual, serious conflict, thereby permitting the court to engage in *de novo* review.") Second, the Ninth Circuit used the treating physician rule in its *de novo* review as a presumption that the treating physician's opinion was correct. *Nord*, 296 F.3d at 831-2 ("Dr. Mitri's opinion is overwhelmed by substantial evidence in the record, including the opinions of three treating physicians"); *Regula*, 266 F.3d at 1139 (" . . . we see no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions.") Under *Firestone*, the Ninth Circuit should not have used the plan's failure to use the treating physician rule as evidence of a conflict of interest; it should not have used the conflict to mandate a *de novo* standard of review; and it should not have viewed the treating physician's opinion as presumptively valid.

> "The treating physician rule was totally inconsistent with the substantial evidence test. It was based on the Second Circuit's unsupported belief that treating physicians' opinions invariably are more reliable than consulting physicians' opinions. Congress, the SSA, ALJs, and independent researchers hold the contrary view: '[A]s a matter of both bias and degree of qualification the consulting physician was likely to be much the better information source.' J. Mashaw, et al, Social Security Hearings and Appeals 57 (1978). . . . "

Pierce, *Administrative Law Treatise* § 11.3.

In this case, Respondent should have borne the burden to prove that the plan administrator's decision denying him benefits constituted an abuse of discretion. In applying its own version of the treating physician rule, the Ninth Circuit fundamentally altered the *Firestone* standard. This artificially constructed burden shift conflicts with *Firestone* and should not be applied to ERISA disability benefit decisions.

B. The Ninth Circuit Used The Treating Physician Rule To Find An Actual Conflict Of Interest Which Tainted Petitioner's Decision To Deny Benefits

In this case, the Ninth Circuit correctly noted that Petitioner's Plan granted the administrator broad discretion over eligibility determinations. However, the Ninth Circuit concluded that Petitioner's denial of benefits was tainted by an actual conflict of interest because the Plan Manager: (1) did not credit the hypothetical opinion of its Human Resources representative, Janmarie Forward; and (2) did not meet the Ninth Circuit's treating physician rule requirements.[16] *Nord,* 296 F.3d at 830. Therefore, the court held that the Plan Manager's decision was presumptively void and should be reviewed *de novo*.[17] *Id.* at 831.

[16] Of course, the Plan Manager did not know that the Ninth Circuit's treating physician rule applied on October 27, 1998, because *Regula* was not reported until September 24, 2001.

[17] Various circuits apply inconsistent levels of review when a conflict of interest exists. *Note: Inconsistency Among The Circuits Concerning The Conflict Of Interest Analysis Applied In An ERISA Action With An Emphasis On The Eighth Circuit's Adoption Of The*

(Continued on following page)

The first reason is not supported by the record. The Ninth Circuit stated that, "Forward opined that Nord was unable, due to his medical condition, to perform the functions of a Material Planner." *Id.* at 830. There is no evidence in the record to support this finding. Forward's opinion in effect was that if Respondent could not get along with his peers, he could not do his job. In addition, her answer was given in response to an incomplete hypothetical posed by Respondent's attorney which ignored whether or not Respondent could have engaged in intense interpersonal relations with legally required accommodation, 42 U.S.C. § 12101 *et seq.* (the Americans with Disabilities Act), or mitigating measures such as medication. *Cf. Sutton v. United Air Lines Inc.,* 527 U.S. 471, 488-489 (1999) (holding that a disability for purposes of the ADA must be construed in light of corrective measures.) It is uncontroverted that Respondent was mediating his back pain by taking medication to control the pain and that his pain was "tolerated with medication," and that his "symptoms are controlled with Relafen, occasional Darvocet and Flexeril." [L:68, 87, 89]

The Ninth Circuit held that the plan administrator failed to give legitimate specific reasons for rejecting the treating physicians' opinions. *Nord,* 296 F.3d at 831. Therefore, the court held that Petitioner had not overcome the presumption of an actual conflict of interest created by

Sliding Scale Analysis In Woo v. Deluxe Corporation, 75 N. Dak. L. Rev. 815 (1999). The Ninth Circuit applies the "presumptively void" test. *Atwood v. Newmont Gold Co., Inc.,* 45 F.3d 1317, at 1322-1323 (9th Cir. 1995).

its treating physician rule. The court gave no consideration to the fact that Petitioner: (1) had relied on the opinion of Dr. Mitri, a neurologist, that Respondent was able to perform his duties with accommodation as a material planner; (2) had given a copy of Dr. Mitri's report to Respondent and twice requested that he obtain the opinion of his treating physician on Dr. Mitri's conclusions, which Respondent failed to do; (3) the treating physician's diagnosis only went to impairment and not to work capacity; and (4) the treating physician's opinion did not address possible workplace accommodation measures such as intermittent standing and sitting and medication. The court shifted the burden from the claimant to show the plan administrator abused his discretion to the plan administrator to prove that there was not an actual conflict of interest that tainted his decision.

Using the treating physician rule as a determiner of actual conflict of interest by the plan administrator conflicts with the abuse of discretion test set out by this Court in *Firestone*. The Court should strike down the test and affirm the abuse of discretion standard in ERISA disability determinations where the plan administrator is given discretion to make benefit decisions or interpret the plan.

C. The Ninth Circuit Used The Treating Physician Rule In Its *De Novo* Review To Test The Reasonableness Of Petitioner's Decision To Deny Benefits

Relying upon its holding in *Regula* that " . . . we see no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions," the Ninth Circuit reviewed the opinions of Respondent's alleged three treating physicians

and the opinion of Dr. Mitri, the independent neurologist. *Nord,* 296 F.3d at 830-1. The court found that Dr. Mitri's opinion was overwhelmed by the opinion of the treating physicians that "Nord's condition rendered him unable to meet the physical requirements of his position as a Material Planner," despite the fact that none of the Respondent's physicians ever expressed an opinion as to Respondent's ability to perform the job of a material planner. *Id.* at 832. Not only did the court shift the burden to Petitioner to provide specific legitimate reasons for rejecting the treating physicians' opinions, the court also erroneously translated the treating physicians' opinions on Respondent's impairment into opinions on his work capacity to perform the job of material planner.

Using the treating physician rule in this manner conflicts with the abuse of discretion standard set out by this Court in *Firestone*. The Court should reverse the Ninth Circuit's plain error and reaffirm that the abuse of discretion standard applies.

D. The Ninth Circuit's Treating Physician Rule Places An Unreasonable Burden On The Plan Administrator

The Ninth Circuit's treating physician rule places an almost insurmountable burden on the plan administrator who believes that the treating physician's opinion is erroneous. As an example, if a podiatrist opined that his patient was disabled from throat cancer, under *Firestone*, the plan administrator could reject that opinion as incompetent and incredible, and all other factors being equal, that opinion would be subject to an abuse of discretion review. In that review, the claimant would have the burden of proving that the administrator's decision was

not based upon substantial evidence. However, under the Ninth Circuit's treating physician rule, the claimant has no burden other than producing the podiatrist's opinion. The administrator, however, has the burden to reject the podiatrist's opinion by specific, legitimate reasons which must be based on substantial evidence in the record; if he fails to do so, then his opinion is subject to a *de novo* review in which the treating physician's rule is used to test whether the plan administrator's decision is reasonable.[18]

The record in this case illustrates the unreasonable burden that the Ninth Circuit treating physician rule places on plan administrators. Instead of focusing on the administrator's decision in this case, the Ninth Circuit focused on the opinions of three doctors who were evaluating a subjective complaint by Respondent. The Ninth Circuit focused on the only objective evidence that was available – that Respondent had a mild degeneration of his spine. However, the Court missed the key issue of: What was Respondent's capacity to perform the job of material planner? If the Court has followed this Court's teachings in *Firestone*, it would have focused on Petitioner's decision and found the substantial evidence in Dr. Mitri's work capacity opinion, saving the plan and the courts from needlessly using their limited resources.

[18] In meeting its burden to reject the treating physician's opinion, the plan administrator will be forced to retain a highly qualified and expensive medical expert to oppose even an incompetent or incredible opinion. Plan administrators have been warned by the Ninth Circuit's opinion in *Nord* that a medical opinion as to impairment and work capacity by an examining neurologist in a back pain case is only "[a] scintilla of evidence that is not significantly probative [and] does not present a genuine issue of material fact." *Nord*, 296 F.3d at 832.

The Ninth Circuit's treating physician rule effectively puts a "thumb on the scale" in favor of the claimant by requiring the administrator to *produce* reasons based upon *substantial evidence* refuting the opinion submitted by the claimant's treating physician, rather than leaving the burden on the claimant to show a *lack of substantial evidence* to support the administrator's decision. A draconian rule which makes the opinion of the treating physician paramount, trumping conflicting medical evidence belies common sense. Where there is conflicting evidence in regard to a claimant's disability, resolution of that conflict should be left to the entity charged with making the decision – the plan administrator. As stated in *Dray v. Railroad Retirement Board* 10 F.3d 1306, 1311 (7th Cir. 1993): "In the case of dueling doctors, it remains the province of the hearing officer to decide whom to believe – a treating doctor whose experience and knowledge about the case may (or may not) be relevant to understanding the claimant's condition, or a consulting specialist who may bring expertise and knowledge about similar cases." This Court should overrule the Ninth Circuit's treating physician rule.

CONCLUSION

This Court should reverse the holding of the Ninth Circuit Court of Appeals that its treating physician rule can be used (1) to show an actual conflict of interest that tainted Petitioner's decision to deny benefits and therefore requires *de novo* review of Petitioner's decision and (2) as a test to determine the reasonableness of the plan administrator's decision. This Court should overturn the reversal of the Order on Summary Judgment and overturn the *sua*

sponte order granting judgment to Respondent and remand the case to the Ninth Circuit with direction to review the Plan Manager's denial of benefits for abuse of discretion consistent with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch.*

Respectfully submitted,

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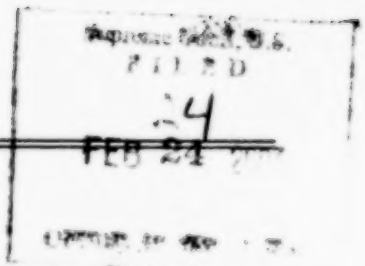

In The

Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

APPENDIX TO PETITIONER'S BRIEF ON THE MERITS

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Guides

to the **Evaluation**
of **Permanent**
Impairment

Fifth Edition

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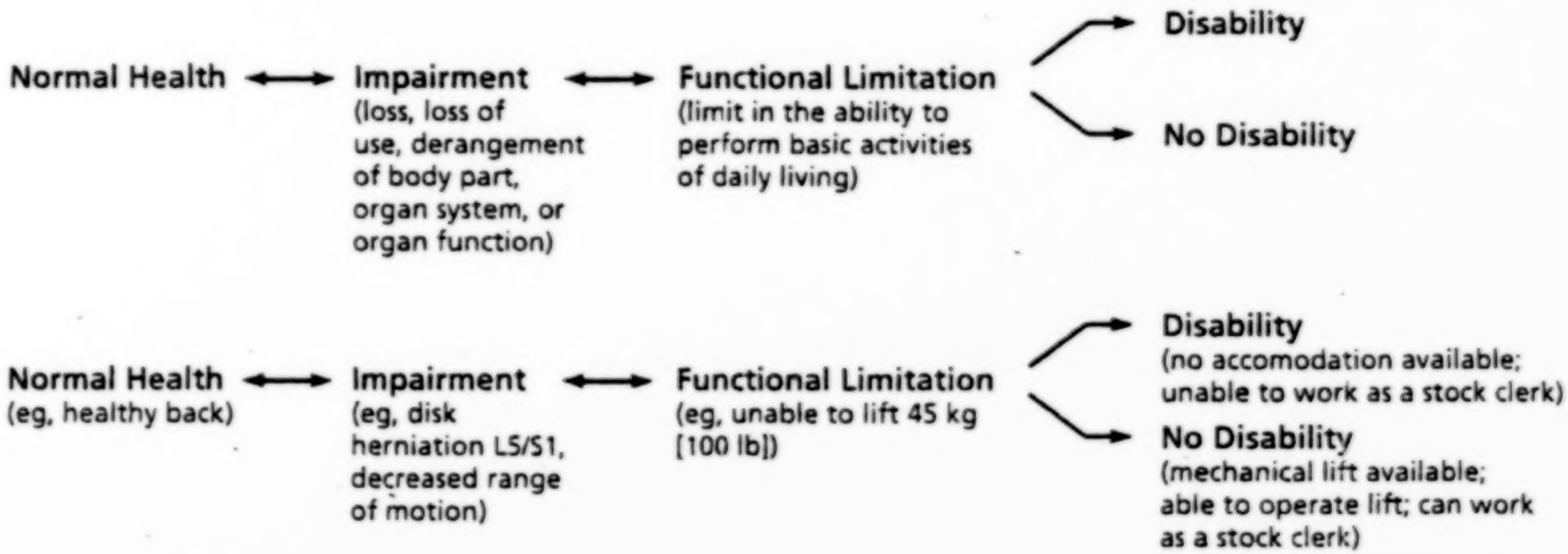
AMA press

1.2b Disability

The term ***disability*** has historically referred to a broad category of individuals with diverse limitations in the ability to meet social or occupational demands. However, it is more accurate to refer to the specific activity or role the "disabled" individual is unable to perform. Several organizations are moving away from the term *disability* and instead are referring to specific *activity limitations* to encourage an emphasis on the specific activities the individual can perform and to identify how the environment can be altered to enable the individual to perform the activities associated with various social or occupational roles. (Table 1-1).

Figure 1-1 The Relationship Among the Concepts of Normal Health, Impairment, Functional Limitation, and Activity Disability (Performance Limitation)



According to a 1997 Institute of Medicine Report, "disability is a relational outcome, reflecting the individual's capacity to perform a specific task or activity, contingent on the environmental conditions in which they are to be performed." Disability is context-specific, not inherent in the individual, but a function of the interaction of the individual and the environment.

The World Health Organization (WHO) is revising its 1980 *International Classification of Impairments, Disabilities and Handicaps* and has released a draft document, *The International Classification of Impairments, Activities and Participation (ICIDH-2)*. The term *disability* has been replaced by a neutral term, *activity*, and limits in ability are described as *activity limitations*. The change in terminology arose for several reasons: to choose terminology without an associated stigma, to avoid labeling, and to emphasize the person's residual ability. Representatives worldwide are reviewing this international classification scale of impairments, function, and activities.

The *Guides* continues to define **disability as an alteration of an individual's capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of an impairment.** An individual can have a disability in performing a specific work activity but not have a disability in any other social role. Physicians have the education and training to evaluate a person's health status and determine the presence or absence of an impairment. If the physician has the expertise and is well acquainted with the individual's activities and needs, the physician may also express an opinion about the presence or absence of a specific disability. For example, an occupational medicine physician who

understands the job requirements in a particular workplace can provide insights on how the impairment could contribute to a workplace disability.

The impairment evaluation, however, is only one aspect of disability determination. A disability determination also includes information about the individual's skills, education, job history, adaptability, age, and environment requirements and modifications. Assessing these factors can provide a more realistic picture of the effects of the impairment on the ability to perform complex work and social activities. If adapations can be made to the environment, the individual may not be disabled from performing that activity.

As discussed in this chapter and illustrated in Figure 1-1, medical impairments are not related to disability in a linear fashion. An individual with a medical impairment can have no disability for some occupations, yet be very disabled for others. For example, severe degenerative disk disease may impair the functioning of the spine of both a licensed practical nurse and a bank president in a similar fashion when performing their activities of daily living. However, in terms of occupation, the bank president is less likely to be disabled by this impairment than the licensed practical nurse. An individual who develops rheumatoid arthritis may be disabled from work as a tailor but may be able to work as a child care aide. A pilot who develops a visual impairment, correctable with glasses, may be able to perform all of his daily activities but is no longer able to fly a commercial plane. An individual with repeated hernias and repairs may no longer be able to life more than 20 kg (40 lb) but could work in a factory where mechanical lifts are available.

The *Guides* is not intended to be used for direct estimates of work disability. Impairment percentages derived according to the *Guides* criteria do not measure work disability. Therefore, it is inappropriate to use the *Guides'* criteria or ratings to make direct estimates of work disability.

1.2c Handicap

Handicap is a term historically used in both a legal and a policy context to describe disability or people living with disabilities. Though the term continues to be used, generally it is being replaced with the preferred term *disability*.

1.3 The Organ System and Whole Body Approach to Impairment

The *Guides* impairment ratings reflect the severity and limitations of the organ/body system impairment and resulting **functional limitations**. Most organ/body systems chapters in the *Guides* provide impairment ratings that represent the extent of whole person impairment. In addition to listing whole person impairments, the musculoskeletal chapters provide regional impairment ratings (eg, upper extremity, lower extremity); regional ratings are then converted into whole person impairment ratings. Within some musculoskeletal regions, a consensus group developed weights to reflect the relative importance of certain regions. For example, different fingers or different areas of the spine are given different weights, representing their unique and relative importance to the region's overall functioning. These weights, which have gained acceptance in clinical practice, have been retained to enable regulatory authorities to convert from a regional body to whole person impairment when needed.

1.4 Philosophy and Use of the Combined Values Chart

The **Combined Values Chart** (p. 604) was designed to enable the physician to account for the effects of multiple impairments with a summary value. A standard formula was used to ensure that regardless of the number of impairments, the summary value would not exceed 100% of the whole person. According to the formula listed in the combined values chart, multiple impairments are combined so that the whole person impairment value is equal to or less than the sum of all the individual impairment values.

18.3e Classes of Pain-Related Impairment

There are four general classes of impairment due to pain: class 1, mild; class 2, moderate; class 3, moderately severe; and class 4, severe (see Table 18-3).

Table 18-3 Impairment Classification Due to Pain Disorders

Class 1 Mild	Class 2 Moderate	Class 3 Moderately Severe	Class 4 Severe
Pain severity, based on a combination of intensity and frequency, is mild Individual's pain is mildly aggravated by performing ADL; is able to perform them with few modifications Individual demonstrates no or only minimal emotional distress in response to his or her pain Individual is not receiving treatment for pain on a regular basis Pain-related limitations during physical examination are mild and appear appropriate; few pain behaviors (overt expressions of pain, distress, and suffering, such as moaning, limping, moving in a guarded fashion, facial grimacing) are observed during examination	Pain severity, based on a combination of intensity and frequency, is moderate Individual has moderate difficulty managing ADL; must make significant modifications in order to perform them (eg, move to a ground floor apartment, buy a car with automatic transmission) Individual demonstrates mild to moderate affective distress in relation to his or her pain Individual requires ongoing medical monitoring and is taking medication much of the time Individual demonstrates significant pain-related limitations on physical examination; relatively few pain behaviors appear during the examination, and they are of indeterminate appropriateness	Pain is present most of the time and may reach an intensity of 9-10/10 Individual can perform ADL only with substantial modifications; unable to perform many routine activities (eg, driving a car) Individual demonstrates moderate to severe affective distress in relation to his or her pain Individual receives medication to control pain on a maintenance basis On physical examination, individual demonstrates severe pain-related limitations that may make the examination difficult to perform and results difficult to interpret A number of pain behaviors are observed during the examination, and they appear to be congruent with organ dysfunction	Pain is essentially continuous, with intensity reaching 9-10/10 at its worst Individual must either get help from others for many ADL (eg, preparing food, dressing), modify them drastically (eg, stop bathing), or spend an inordinate amount of time accomplishing them (eg, 2 hours to get out of bed and dressed) Individual demonstrates severe affective distress in relation to his or her pain and communicates the perception that the pain is completely out of control Individual is receiving maximal pharmacologic support for his or her pain on an ongoing basis Physical examination is virtually impossible to perform because individual is intolerant of many examination maneuvers (eg, refuses to ambulate or to allow examiner to palpate symptomatic area); a significant number of pain behaviors are observed during the examination, and they appear to be congruent with organ dysfunction

18.3f How to Rate Pain-Related Impairment: Practical Steps

There are six steps in the pain-related impairment evaluation process, each discussed below. Several alternative methods are available to evaluate the severity of pain, activity restrictions, emotional distress, and pain behaviors, some of which are discussed subsequently. One such methodology is provided in Table 18-4. The first three parts of the protocol included in Table 18-4 rely on the individual's self-report. The questions may be provided to the individual to complete on his or her own, or they can be presented in interview format. If the individual is asked to complete the questionnaire on his or her own, someone should be available to answer questions and to review the completed form to make sure the individual has responded to all the items. If the individual has a question about completion of any of the items in Sections I to III, he or she should be instructed to make the best estimate possible. Although Table 18-4 provides a numerical score, this should not be misunderstood to represent a quantitative impairment rating, but rather is used to classify individuals into the four qualitative classes. To that purpose, alternative methods may be used so long as they are valid and appropriately referred to in the report.

Table 18-4 Ratings Determining Impairment Associated With Pain

Name:_____ **Date:**_____

I. Pain (Self-report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Activity does not aggravate pain — Excruciating following any activity

Sum score of Section I: A–D = Total pain severity/4 = _____

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Rarely — All of the time

Add total pain severity score (items A–D/4) to score for item E = _____

Total pain severity score (range from 0 to 20) = _____

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for 1/2 hour — Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Pain does not interfere with ability to stand at all — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities — Completely interferes with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely unable to do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to shower or bathe without help

M. How much does your pain interfere with your ability to **write or type?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to **concentrate**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

Sum score of Section II:
A-P = Total score for activity limitation/16 =
Mean activity limitation = _____

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week. (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable — Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse**?

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

Sum score of Section III:
A-E = Total pain impairment attributed to mood state/5 =
Mean score = _____

Assess Whether the Individual is at MMI

This concept is particularly important in the assessment of pain-related impairment. A person should not be judged medically stable, and therefore ratable, unless he or she has undergone a thorough evaluation for the entire range of factors that can affect pain and has undergone a vigorous trial of rehabilitative treatment.

For example, there may be no further orthopedic interventions available for a lumbar pseudarthrosis. Spinal arachnoiditis may be refractory to any intervention. Yet in both cases, appropriate pain management may reduce all the components of impairment, with reduced pain severity, functional restoration, and mood normalization. Consultation with a specialist in pain medicine may be required to determine whether the impairment is fixed or potentially useful treatments are available.

Determine the Severity of the Pain

Although absolute quantification of pain is not possible, severity may be estimated using, for example, a visual analog scale, a numeric, or a box-rating scale. A horizontal or vertical line of known length is anchored by "no pain at all" at one end and "worst pain ever" at the other. A line of consecutive boxes also anchored with these end points, with a number in each one and in which the individual is asked to place an "X" in the box, may be of particular use because some people have difficulty understanding how to use a VAS scale. It is useful to obtain least, worst, and current levels, as well as the usual level. Exacerbating and mitigating factors should be sought. The character or

quality of pain may assist with diagnosis and help establish that the pain is compatible with a known medical syndrome.

The McGill Pain Questionnaire is widely used in pain medicine. It contains lists of words chosen to reflect the sensory (eg, dull, cramping), affective (eg, agonizing, terrifying), and evaluative (eg, annoying, unbearable) components of the pain experience. There are also descriptors of the temporal qualities of the pain (momentary, steady, intermittent). Line drawings of the body permit the individual to shade in the location of the pain. Numeric descriptors of the overall present pain intensity are provided (1 = mild, 2 = discomforting, 3 = distressing, 4 = horrible, 5 = excruciating).

Determine Activity Restrictions

The reported severity of pain may not correlate well with its functional impact. Indeed, some individuals report well-preserved function despite pain of 9/10 in severity, while others portray a vegetative existence with a pain level of 4/10. It is essential to know the extent to which the following functions are impeded by *pain*: ADL, socialization, recreation, work, sleep, sexuality, and cognition.

A quasi-quantification of functional status can be derived by scoring the extent to which pain interferes with each (applicable) activity. The individual should be queried as to how often he or she leaves the home (with documentation if housebound), gets out only for medical appointments, and the like. "Down time," the total number of hours a day the person is reclining, is a useful measure.

It is useful to provide quantification of functional limitations via accepted, standardized instruments that permit interrater comparisons. The Pain Disability Index provides 0 to 10 scales on which individuals rate pain-related interference in seven domains, including family/home responsibilities, recreation, social activity, occupation, sexual behavior, self-care, and life support activities (eating, sleeping, breathing). The SF-36 is widely used to determine the degree of functional impairment and changes in overall wellness following treatment of those with pain as well as of other populations. The Oswestry and Roland-Morris are brief questionnaires that provide an economical office assessment of function in individuals with back pain. A large number of other instruments exist, as reported in the literature. It is also possible to correlate estimates of function to actual impairment using questionnaires and scales.

The ADL listed in Table 1-2 are commonly classified within one of eight different areas: physical activity, nonspecialized hand activities, sleep, travel, self-care and personal hygiene, sexual function, communication, and sensory function. The first six of these are most relevant for impairment due to pain, as it is extremely rare for pain to create major restrictions in communication and sensory functioning. A number of measures have been developed to assess ADL, some of which are general and others of which are designed for use with specific diseases and injuries. Physicians may choose to select from among the available ADL scales if they wish a more detailed assessment. Although individuals may have difficulty separating the effect of specific diseases or injuries from the pain on their activities, some estimate is necessary to help in determining the extent of impairment due to pain that

exceeds activity restriction due to the disease or injury. For example, an individual with a below-the-knee amputation may have some activity limitations in ambulation; he or she may have additional limitations due to severe stump pain.

Several well-established general measures have been standardized on chronic pain sufferers and have been used in numerous published studies that may be of particular use as they assess several important domains relevant to the assessment of impairment. For example, the Sickness Impact Profile (SIP) is a widely used health status measure that has been shown to reliably assess the impact of health problems on function and quality of life. The West Haven – Yale Multidimensional Pain Inventory (MPI) is another reliable and valid health status measure that has been used extensively.

Determine the Presence of Emotional Distress

An important component of chronic pain-related impairment is its associated affective distress, which often includes sadness, anger or irritability, and anxiety. In some cohorts, the depression seems to be primarily a function of life interference and cognitive changes, while in others it seems to be primarily a function of the pain itself. In either case, it is unnecessary that an individual meet diagnostic criteria for a mood, anxiety, or other psychiatric disorder for there to be substantial suffering related to such issues as pain, loss of meaningful and pleasurable life activities, and a bleak future.

It may be appropriate to use rating scales to provide some quantification of affective changes. Brief self-administered screens for depression, such as the Beck Depression

Inventory, The Zung Depression Index, and rater-administered screens such as the Hamilton Self-rating Scale for Depression, may alert the physician to the presence of a mood disorder that requires treatment, as well as to the possibility of suicide. Similar instruments are available for anxiety and include the Beck Anxiety Scale and Hamilton Rating Scale for Anxiety. The Profile of Mood States (POMS), which has also been useful in providing quantification of various mood states in individuals with chronic pain, has scales reflecting impaired concentration, anxiety, depression, fatigue, and others.

As with pain reports, these instruments all are subject to minimization or exaggeration on the part of the individual. People are seen who score four times the cutoff for depression on the Beck Depression Inventory, yet who are animated and playful in the gym. When such discrepancies occur, the weighting given the instrument should be minimal. Moreover, caution must be taken in interpreting responses on these measures, as they are not standardized on samples of individuals with medical disorders, and using the usual cutoff scores may lead to an excessively large number of false positives.

It is important to obtain information from the individual regarding the impact of pain on his or her mood state. As noted in the discussion of activity restrictions, it may be difficult for the individual to separate the effect of specific diseases or injuries from the pain on activities; however, the items are designed to obtain a rough estimate of the individual's beliefs.

Determine if Pain Behaviors Are Present

Pain behaviors are the ways that individuals communicate about their pain. These behaviors may be verbal or nonverbal. The individual may be unaware of them, as they may be emitted and maintained due to responses that have been received from significant others, including health care professionals. In other instances, individuals may exaggerate their behaviors to signal pain and distress with the intent to achieve some desired response from those who observe the behaviors. Thus, both the antecedents and consequences of the behaviors are important.

Some individuals appear stoic as they go through evaluations, and the pain behaviors they do demonstrate are concordant with other medical information regarding their condition. In this instance, the pain behaviors provide valuable clues regarding a person's diagnosis and tend to validate the fact that he or she is suffering because of the diagnosed condition. For example, consider an individual with suspected degenerative joint disease of the hip who walks with a characteristic limp. The limp provides a clue to the diagnosis and tends to support the individual's reports that he or she has significant pain when walking.

At the opposite extreme, an individual may demonstrate pain behaviors that appear exaggerated and discordant with his or her presumed medical condition. These pain behaviors may appear to be driven by a variety of factors, such as overwhelming somatic anxiety or the person's desire to convince an examiner that he or she is suffering greatly. The common denominator underlying them is that they do not appear to be direct, inevitable consequences of a definable medical condition. Exaggerated, discordant

pain behaviors tend to cast doubt on the validity of the information that people provide regarding their condition.

Thus, an examiner has a twofold task regarding pain behaviors demonstrated by a person undergoing an impairment rating: to identify the pain behaviors, and to interpret their significance, that is, to decide whether they tend to authenticate the validity of the individual's suffering or to raise questions about his or her communication style.

It is hard to specify a generic list of pain behaviors. The behaviors to look for depend on the individual's medical condition, examination maneuvers that are performed, previous responses obtained, and intent. Physicians probably differ significantly in what they view as exaggerated pain behaviors. Sources of variation include different concepts of what represents "legitimate disease" and thresholds for calling a behavior abnormal.

Despite the limitations noted, pain behaviors provide useful information regarding both the impact of pain on observable behavior and the individual's style of communicating (eg, demonstrative, stoic) about their pain. The physician should observe the individual's pain behaviors as he or she enters the examination room, during the interview, and during the history taking. This will eliminate the increase in pain behaviors that might be directly associated with the physical examination.

The examiner should give a score between +10 and -10 to indicate his or her global evaluation of an individual's pain behavior during the interview and physical examination. A positive score is given when the individual demonstrates pain behaviors that are concordant with the overall clinical findings and, in the opinion of the examiner, tend

to authenticate his or her suffering. A negative score is given when an individual demonstrates grossly "nonorganic" or "exaggerated" pain behaviors. A score close to 0 should be given when the examiner is uncertain about how to interpret the individual's pain behaviors.

The specific behaviors an examiner considers vary according to the individual's medical condition and the examination maneuvers performed. Potentially significant behaviors that commonly occur during evaluations are listed in Table 18-5. Note that the significance of pain behavior cannot be determined unless related to a particular individual and context. Thus, a pain behavior that would be considered concordant in one clinical context would be considered discordant in a different one. Also, note that pain behaviors that tend to validate an individual's pain are generally specific to that person's medical condition. In contrast, exaggerated pain behaviors – such as emotional displays and pain-limited weakness – tend to occur in conjunction with a wide variety of medical conditions.

The physician can record the pain behaviors observed using the behaviors listed in Table 18-5. These behaviors may be viewed as indicating symptom magnification, especially when several are present and they grossly exceed what might be expected from individuals with a similar diagnosis. These systematic observations should be used as the basis for determining a global rating regarding the presence and congruence of pain behaviors given the individual's diagnosis and organ dysfunction.

Table 18-5 Assessment of Pain Behavior

Observable Pain Behaviors
Note the presence of any of the following behaviors during the interview and examination:
1. Facial grimacing
2. Holding or supporting affected body part or area
3. Limping or distorted gait
4. Frequent shifting of posture or position
5. Extremely slow movements
6. Sitting with a rigid posture
7. Moving in a guarded or protective fashion
8. Moaning
9. Using a cane, cervical collar, or other device
10. Stooping while walking
11. Other: _____
Based on the behaviors above and knowledge of the individual's diagnosis and organ dysfunction, rate the pain behaviors by giving them a score between +10 and –10. You may give any score between +10 and –10.

–10	**0**	**+10**
Pain behaviors are exaggerated, nonphysiologic	Pain behaviors are mixed or ambiguous	Pain behaviors are appropriate and tend to confirm other clinical findings

Global pain behavior score = _____

Credibility of the Individual

Physicians routinely assess the credibility of individuals in the course of their clinical work. This kind of assessment is particularly important in the context of rating pain-related impairment because the ratings depend on verbal and nonverbal behaviors of people that are at least partly under voluntary control. Although there are no definite rules for assessing credibility, Section 18.4, Behavioral Confounders, discusses several issues that a physician should consider when making a judgment about a person's credibility.

The key question the examiner should ask, is Do the limitations that an individual describes and demonstrates accurately reflect the burden of illness he or she bears during everyday activity?

18.4 Behavioral Confounders

An extensive literature demonstrates what common sense suggests: pain behaviors and perception of pain are strongly influenced by beliefs, expectations, rewards, attention, and training. In the absence of a direct measure of pain, such behaviors function as markers by which pain is judged. However, voluminous literature demonstrates that these markers reflect social and environmental factors as much as they reflect pain. It has been shown, for example, that individual ratings of pain severity diminish when "well talk" is reinforced. With repeated identical pain stimuli, intensity reports vary with feedback. Verbal reinforcement increases performance in individuals with back pain. Studies consistently show that spouse solicitousness is correlated with pain behavior.

Prospective studies consistently show that onset of disabling pain is highly associated with such factors as job dissatisfaction, lack of support at work, stress, and perceived inadequacy of income. Once initiated, the progression of pain to chronicity is contingent on similar factors. Financial compensation, receipt of work-related sickness payments, and compensation-related litigation are also associated with chronicity, as are such social and economic factors as poor education, language problems, and low income. Chronicity is also favored by individual tendencies to be preoccupied with one's body and symptoms. Even in individuals with clear-cut radicular pain from disk prolapse/protrusion, application for retirement at 6 months was best predicted by depression and daily hassles at work. In the case of injured workers, performance on functional capacity evaluation is reduced if the worker is informed that the test results will be used to determine work classification. Industrial injuries and compensation situations appear to provide a disproportionate number of individuals with such issues.

Although the suffering induced by a miserable vocational situation may equal or exceed that from disease or injury, it is the intent of the *Guides* to assign impairment based on disease and injury, not on such environmental situations as an individual's fear of returning to a hostile work environment. Similarly, the physician charged with assigning an impairment rating expects to discharge the obligation by assessing the state of the person as an organism, and he or she rightly considers such external factors as the state of the economy, the market for particular skills, and the local tolerance for language barriers to be distractors that lower the "signal-to-noise" ratio in the assessment.

Thus, examiners face a dilemma. They know that a variety of nonbiological factors strongly influence the disability status and ADL deficits of individuals they rate, but they are charged with the task of rating impairment on the basis of measurable dysfunctions of organ or body parts.

Physician Manipulation of Reimbursement Rules for Patients
Between a Rock and a Hard Place

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Context Health plan utilization review rules are intended to enforce insurance contracts and can alter and constrain the services that physicians provide to their patients. Physicians can manipulate these rules, but how often they do so is unknown.

Objective To determine the frequency with which physicians manipulate reimbursement rules to obtain coverage for services they perceive as necessary, and the physician attitudes and personal and practice characteristics associated with these manipulations.

Design, Setting, and Participants A random national sample of 1124 practicing physicians was surveyed by mail in 1998; the response rate was 64% (n = 720).

Main Outcome Measure Use of 3 different tactics "sometimes" or more often in the last year: (1) exaggerating the severity of patients' conditions; (2) changing patients' billing diagnoses; and/or (3) reporting signs or symptoms that patients did not have to help the patients secure coverage for needed care.

Results Thirty-nine percent of physicians reported using at least 1 tactic "sometimes" or more often in the last year. In multivariate models comparing these physicians with physicians who "never" or "rarely" used any of these

tactics, physicians using these tactics were more likely to (1) believe that "gaming the system" is necessary to provide high-quality care today (odds ratio [OR], 3.67; 95% confidence interval [CI], 2.54-5.29); (2) have received requests from patients to deceive insurers (OR, 2.44; 95% CI, 1.72-3.45); (3) feel pressed for time during patient visits (OR, 1.69; 95% CI, 1.21-2.37); and (4) have more than 25% of their patients covered by Medicaid (OR, 1.60; 95% CI, 1.08-2.38). Notably, greater worry about prosecution for fraud did not affect physicians' use of these tactics (P = .34). Of those reporting using these tactics, 54% reported doing so more often now than 5 years ago.

Conclusions A sizable minority of physicians report manipulating reimbursement rules so patients can receive care that physicians perceive is necessary. Unless novel strategies are developed to address this, greater utilization restrictions in the health care system are likely to increase physicians' use of such manipulative "covert advocacy" tactics.

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PHYSICIANS' DECISIONS ABOUT what services to offer their patients affect almost 80% of all health care expenditures and have an enormous influence on health care quality.[1,2] To control cost and quality and ensure adherence to their contracts, health care delivery organizations and payers frequently review physician recommendations and pay for services (eg, diagnostic tests, drugs, or hospitalization for treatment) only in predefined circumstances. This utilization review may occur prospectively, in the form of preauthorization; concurrently, requiring immediate approval over the telephone; or retrospectively, with payment decision being made after services have been delivered.

Specific utilization review criteria are rarely spelled out in advance; what physicians agree to when they sign health plan contracts varies greatly and may both alter and constrain physicians' decisions regarding their patients' use of services.

Although utilization review may be intended to improve quality and save money, many physicians and patients dislike conforming to its rules. Utilization review is often viewed as overly time consuming, a hassle, and an undue questioning of professional authority.[3,4] Appealing adverse coverage decisions may seem inconvenient, unproductive, or even risky for physicians. In some cases, physicians may feel trapped between professional obligations to advocate for their patients and conflicting contractual obligations to follow coverage rules. Furthermore, it has been suggested that some insurers are "gaming" patients and physicians – tricking them into paying for covered services by routinely denying coverage but then approving services that are subsequently appealed, knowing that time and other constraints will prevent some appeals.[4-6] To retaliate, physicians may be tempted to turn the tables.

Physicians could manipulate reimbursement rules to help their patients obtain coverage of care that the physicians perceive to be necessary, for example, through ambiguous documentation or by exaggerating the severity of patients' conditions.[7-9] This sort of deception of third-party payers has been called "gaming the system" for patients[5] and it is not a new idea, nor is it limited to managed care. Fee-for-service payment often provides a greater financial incentive for physicians to manipulate reimbursement rules since they directly profit from increased services. Yet recent data suggest that physicians

in regions with higher managed care penetration are more likely to condone manipulating reimbursement rules.[9] Some may believe that it is necessary to manipulate reimbursement rules in the course of patient advocacy today – even in the face of well-publicized crackdowns on fraud and abuse.[10-12] These physicians may see manipulation of reimbursement rules as an indirect, or convert, form of patient advocacy and even a professional obligation.

Previous studies have posed hypothetical coverage dilemmas to physicians and offered deception to physicians and offered deception of insurers as potential solutions.[9,13,14] These studies demonstrate that many physicians believe there are scenarios in which manipulating reimbursement rules would be justifiable in theory. Anecdotes suggest that using such tactics is not merely hypothetical but occurs in practice.[15] This study sought to determine how many physicians are manipulating reimbursement rules to get coverage for their patients' needed care, and what factors might affect how frequently physicians circumvent utilization review in practice.

METHODS

Physician Sampling

We performed a self-administered mailed survey of physicians in 1998, using a random sample of 1350 physicians from the American Medical Association (AMA) Masterfile of all physicians practicing in the United States. Physicians who were deceased, retired, or no longer seeing patients; who had moved with no forwarding address; or who were in training were excluded, bringing the final sample to 1124 eligible physicians.

Data Collection

Because of the sensitive legal nature of the survey questions, an independent survey research firm, the National Opinion Research Center at the University of Chicago, Chicago, Ill, conducted all mailings and telephone calls, and all potentially identifying information for respondents, including city of residence, was removed from the data set prior to its release to the research team. Respondents were informed in the cover letter that the information would remain strictly confidential. It is not possible to track data back to identifiable individual respondents or health plans using the hard copies of the surveys. The study protocol was approved by an independent institutional review board (Western IRB, Olympia, Wash).

Questionnaires were mailed with a modest financial incentive enclosed (average value, $10). Those who did not respond to the initial mailing of the survey received up to 3 follow-up mailings and 2 telephone calls. In the second call, physicians were given the opportunity to respond by telephone interview.

Variables

Dependent Variable. Questionnaire items were developed from the literature,[3] from a 1996 pilot survey of 134 physicians attending a professional meeting,[7] and from a focus group of practicing physicians. Our dependent variable was whether the physician had manipulated reimbursement rules "to help patients secure coverage for needed treatments or services" in the last year. This was operationalized as the frequency of using 3 general strategies: exaggerating the severity of the patient's condition, changing the patient's official (billing) diagnosis, and/or

reporting signs or symptoms that the patient did not have. These 3 items were each reported on 5-point Likert scales ("never" to "very often"). Descriptive statistics showed that all 3 of these variables had skewed distributions, and, using confirmatory factor analysis, we determined that the 3 items clustered together and the resulting scale had acceptable internal consistency reliability (Cronbach α = .68). Therefore, we felt it was appropriate to use these 3 variables to create a dichotomized summary variable for a multivariate model. Based on their distributions, we made an a priori decision (ie, before examining results of bivariate and multivariate analyses) to dichotomize each of these variables such that "never" and "rarely" were in 1 group and "sometimes," "often," and "very often" were in the other. The 3 items were then aggregated into a single dichotomous variable such that those who answered "never" or "rarely" to all 3 items were in 1 group and all other physicians were in the other.

Independent Variables. We hypothesized that a number of personal and practice characteristics might affect a physician's propensity to manipulate reimbursement rules. We examined characteristics such as number of years in practice; specialty; country of origin, employment type; average number of patients seen each week; number of managed care contracts; proportion of income from capitated, fee-for-service, or salary payments; and total proportion of income at risk for the costs of patient care.

We assessed physicians' attitudes using a series of items that asked for agreement or disagreement on a range of statements, using 5-point Likert scale responses ("strongly agree" to "strongly disagree"). Each of these items was collapsed for analysis into 3 categories: those

who agreed (including "agree" or "strongly agree"), those who disagreed (including "disagree" or "strongly disagree"), and those who were not sure.

One item asked whether physicians agreed that "today it is *necessary* to game the system to provide high-quality care" (italics in the original). Three statements were designed to measure whether the respondent believed that "gaming the system" was a legitimate part of patient advocacy: (1) "In general, it is ethical to game the system for your patient's benefit"; (2) "It is a physician's responsibility to advocate for his/her patient's needs even if it involves exaggerating the severity of the patient's condition to third parties"; and (3) "Assuming your intent is to further a patient's interest, exaggerating the severity of a patient's condition to an insurer is okay." These items were intercorrelated (all correlation coefficients >0.5) so that only the results for item 1 are reported. Other items addressed numerous potentially relevant attitudes and experiences, including "All things considered, I am satisfied with my medical practice"; "I feel financially secure"; "Worry about prosecution for fraud prevents me from exaggerating patients' conditions to third parties"; and "I have enough time with each patient to get everything done that I need to."

Three statements addressed physicians' perceptions of the inconvenience involved in the utilization review process: (1) "Appealing an adverse utilization decision usually takes an excessive amount of my own time"; (2) "I find insurance company intrusion into medical decision making extremely annoying"; and (3) "Appealing adverse utilization decisions is a tremendous hassle." We used these items to form a 3-to-15-point scale confirmed by factor analysis (Cronbach α = .68), which we call the

Hassle of Utilization Review Scale. Physicians scoring higher on this scale felt more inconvenienced by utilization review. Finally, physicians were asked how often in the last year patients had requested that the physician "in some way deceive their third-party payer to help them secure coverage for a service."

Analyses

Bivariate relationships between the dichotomous summary gaming variable and each independent variable were assessed using *t* tests for comparisons that used continuous variables and x^2 tests for those that used ordered variables. Variables with bivariate relationships to the dependent variables of $P \leq .20$ were candidates for the multivariate model. Multivariate logistic regression models were estimated using forward and backward selection methods. Identical independent variables were significant using both criteria, so a straight-entry model was created using those variables, and those results are presented. To obtain adjusted odds rations (ORs) in these models, continuous variables were dichotomized at reasonable cut points based on their distributions and clinical importance. For categorical variables with "agree," "disagree," and "not sure" categories, the "agree" and "not sure" categories were each compared with the "disagree" category. One categorical variable ("How often have your patients requested that you in some way deceive their third-party payer to help them secure coverage for a service?") had 5 response options, from "never" to "very often." This variable was dichotomized by collapsing the "never" and "rarely" categories and the "sometimes,"

"often," and "very often" categories. All analyses used in the SPSS statistical program (SPSS Inc, Chicago, Ill).

RESULTS

Respondent Characteristics

The 720 physicians (response rate, 64%) who completed the questionnaire did not differ from nonrespondents on any available demographic variables. Respondents represented a range of incomes, types of practice, and specialties, as shown in TABLE 1. Most (80%) were men, had been in practice more than 10 years (mean, 17 years), and were in active clinical practice (seeing a mean of 86 patients per week). In all but 1 respect, the demographic frequencies in Table 1 are also similar to available national statistics.[16] For unexplained reasons, our overall random sample contained a larger-than-usual proportion of foreign-born physicians (nearly 40%) compared with nationally (27% in the AMA Masterfile; Tom Pasco, written communication, July 21, 1999). However, foreign-born physicians were not more likely to complete the questionnaire and there were no differences in our dependent variable or its components between foreign-born and US-born physicians.

Table 1. Characteristics of Survey Respondents and Nonrespondents*

	Respondents	Nonrespondents	*P* Value†
Male sex, No. (%)	573 (80)	316 (81)	.68
Employment type, No. (%)			
Self-employed	218 (30)	103 (26)	.57
Group practice	277 (39)	137 (35)	
Hospital/medical school employee	78 (11)	53 (14)	
Other	147 (20)	99 (25)	
Country of origin, No. (%)			
United States	431 (59.9)	234 (59.7)	.97
Canada	8 (1.1)	5 (1.3)	
Other	281 (39.0)	153 (39.0)	
Population of practice area, No. (%)			
Metropolitan (≥50 000)	627 (87)	348 (89.9)	.42
Nonmetropolitan (<50 000)	83 (12)	39 (10.01)	
Specialty, No. (%)‡			
General internal medicine	85 (11.6)	. . .	. . .
Family practice	96 (13.3)	. . .	. . .
Pediatrics	72 (9.9)	. . .	. . .
Internal medicine subspecialties	90 (13)	. . .	. . .
Surgical specialties	159 (23)	. . .	. . .
Other	199 (28)	. . .	. . .
Years of practice, mean (median)	17 (13)	. . .	. . .
No. of patients per week, mean (median)	86 (80)	. . .	. . .
Annual income, No. (%)			
≤$149 000	336 (48)	. . .	. . .
$150 000-$249 000	247 (34)	. . .	. . .
≥$250 000	107 (15)	. . .	. . .
Income at risk for the costs of patient care, mean (median), %	14 (5)	. . .	. . .
Physicians who report any recent practice-related income loss, No. (%)	313 (44)	. . .	. . .
Source of income, mean (SD), %			
Fee-for-service payments	21 (37)	. . .	. . .
Salary payments	23 (39)	. . .	. . .
Capitated payments	3 (12)	. . .	. . .
No. of managed care contracts, mean (median)	12.3 (6)	. . .	. . .
Medicare recipients, mean (median), % of patients	28 (25)	. . .	. . .
Medicaid recipients, mean (median), % of patients	17 (10)	. . .	. . .

*Ellipses indicate data not available. Percentages may not sum to 100 due to rounding.
†Data were calculated using the 2-tailed χ^2 test.
‡Data shown were collected directly from respondents (primary data) and are not comparable with American Medical Association Masterfile data. Primary data are more reliable than Masterfile data in regard to specialty, so primary data were used for subsequent bivariate and multivariate analyses. When Masterfile data comparing respondents' and nonrespondents' specialties were analyzed (not shown), only small differences were found within specialties, though some were statistically significant. Using Masterfile data, the strongest statistical finding was that among surgeons, there was a slightly higher percentage of respondents than nonrespondents (19.4% vs 14.9%; $P<.001$). The 3 primary care specialties (general internal medicine, family practice, and pediatrics) were collapsed to a single category (primary care physicians) for bivariate and multivariate analyses.

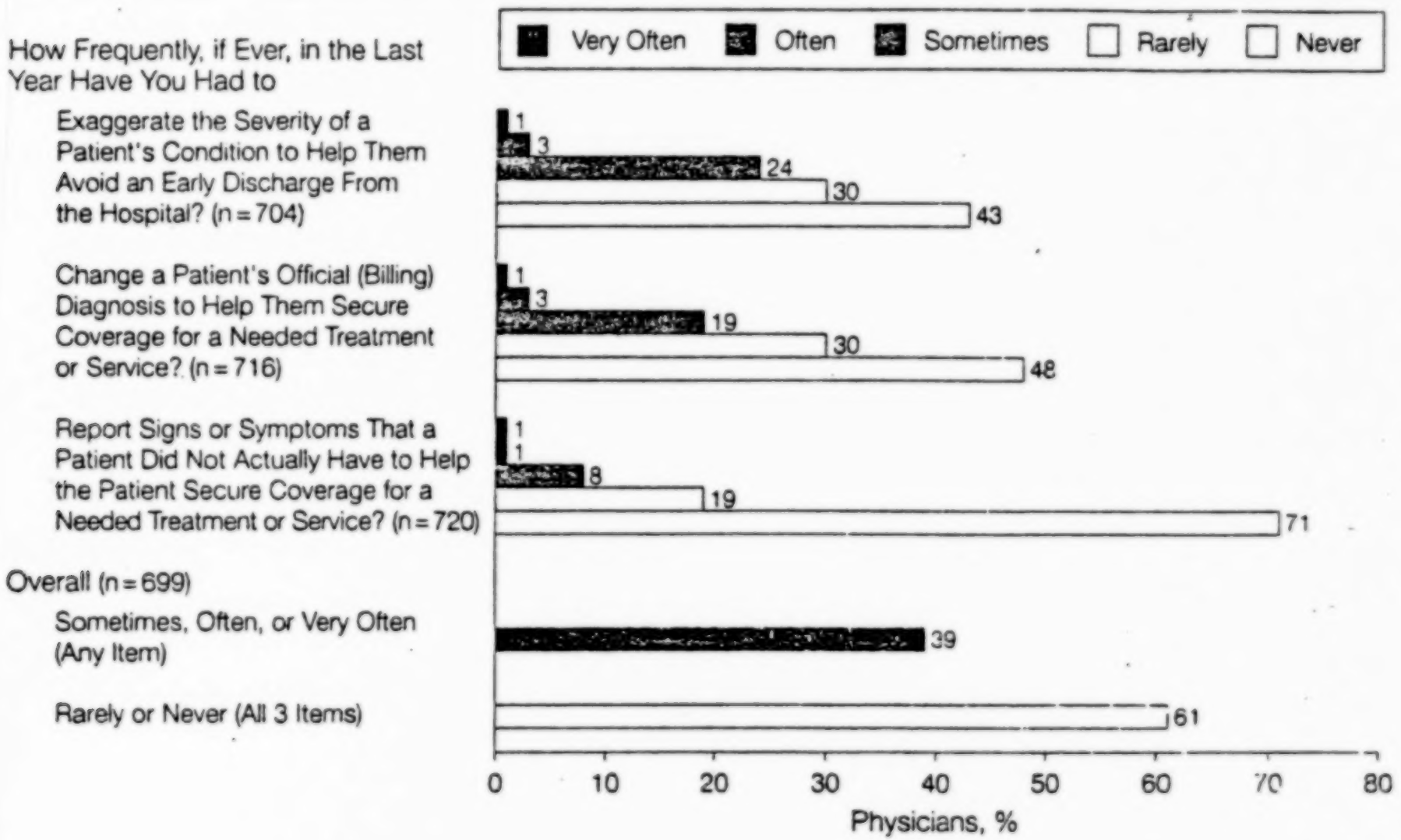
Frequency of Manipulation

The FIGURE shows physicians' reported use of 3 ways to manipulate reimbursement rules, using the exact wording of the survey items. Exaggerating the severity of patients' conditions to help them avoid early hospital discharge was the most commonly used tactic, with 28% of respondents reporting that they had done this sometimes or more often in the last year. Almost as many respondents (24%) reported having changed patients' official (billing) diagnoses, while 10% had recorded signs or symptoms that patients did not actually have to help them secure coverage for needed care.

Altogether, 275 physicians (39%; Figure) reported that they had sometimes, often, or very often used at least 1 of the 3 tactics for manipulating reimbursement rules, and 424 (61%) had rarely or never used any of the tactics in the last year. While we dichotomized respondents in this way to create our dependent variable for subsequent analyses, it may be of interest that 193 respondents (28%) reported never using any of the 3 tactics, while only 3 physicians (0.4%) reported using all 3 tactics often or very often and 49 (7%) reported using at least 1 manipulative tactic often or very often.

We also asked each physician who reported using any of these 3 tactics in the last year whether "you find yourself using deception of third-party payers to obtain needed benefits for patients" more or less often now than 5 years ago. Fifty-four percent responded "more often," while 12% reported doing so less often and the rest said it was unchanged.

Figure. Frequency of Physicians' Use of 3 Tactics to Manipulate Reimbursement Rules



Physicians' Attitudes and Experiences

As shown in TABLE 2, 28.5% of physicians agreed with the statement, "Today it is *necessary* to game the system to provide high quality care" and 15.3% agreed with the statement, "In general it is ethical to game the system for your patients' benefit." These 2 items were strongly associated ($x^2_{16} = 187.5$; $P<.001$); among those who believed that gaming the system is necessary, 42.9% also believed it was ethical, while among those who did not think gaming is necessary, only 4.2% believed it was ethical. Given this significant association, only the first item was used for subsequent statistical analyses, yet it is of interest that even among those who believed that gaming the system is necessary, the majority (57.2%) did not believe that it was ethical.

The Hassle of Utilization Review scale had a mean score of 12.8 (median, 13; range, 3-15). The middle value for this scale was 9, so a mean of 12.8 indicates that, on average, physicians fell between "agree" and "strongly agree" on these items. Roughly 58% of physicians were satisfied with their practice, 47% felt financially secure, 57% reported that worry about prosecution for fraud might prevent them from exaggerating patients' conditions to third-party payers, and 44% believed they had enough time with each patient to get everything done that they needed to. Finally, more than 1 in 3 physicians (37%) reported that their patients sometimes, often, or very often requested that they deceive third-party payers to help them obtain coverage for services in the last year.

Table 2. Physicians' Agreement With Selected Statements Related to Attitudes and Experiences Regarding Manipulating Reimbursement Rules (N = 720)*

Variables	Response, %
Today it is *necessary* to game the system to provide high-quality care	28.5
In general, it is ethical to game the system for your patients' benefit	15.3
Hassle of Utilization Review scale score, mean (SD) [range]†	12.8 (2.2)[3-15]
All things considered, I am satisfied with my medical practice	58.3
I feel financially secure	47.4
Worry about prosecution for fraud prevents me from exaggerating patients' conditions to third parties	56.5
I have enough time with each patient to get everything done that I need to	43.6
Patients request that I deceive their third-party payer‡	37.0

*Response includes percentage responding "agree" or "strongly agree," unless otherwise noted.

†The Hassle of Utilization Review scale rated a combination of 3 statements, including (1) "Appealing an adverse utilization decision usually takes an excessive amount of my own time"; (2) "I find insurance company intrusion into medical decision making extremely annoying"; and (3) "Appealing adverse utilization decisions is a tremendous hassle." See "Methods" section of text for more information.

‡Response includes percentage responding "sometimes," "often," or "always."

Table 3. Significant Bivariate Relationships of Independent Variables to Manipulating Reimbursement Rules

Variables	% Reporting Manipulation of Reimbursement Rules*		*P* Value for Difference
	Yes	No	
Patients request that I deceive their third-party payer, "sometimes," "often," or "always"	50.5	27.2	<.001†
Today it is *necessary* to game the system to provide high-quality care, "agree" or "strongly agree"	64.3	35.7	<.001†
Hassle of Utilization Review scale score, mean (range, 3-15)	13.2	12.4	<.001‡
I have enough time with each patient to get everything done that I need to, "agree" or "strongly agree"	35.8	48.8	<.001†
More than 25% of patients covered by Medicaid, %	20.6	15.3	.002‡
All things considered, I am satisfied with my medical practice, "agree" or "strongly agree"	51.6	63.0	.003†
I feel financially secure, "agree" or "strongly agree"	40.4	52.6	.002†
Worry about prosecution for fraud prevents me from exaggerating patients' conditions to third-party payers, "agree" or "strongly agree"	42.3	57.7	.04†

*Physicians who used at least 1 of the tactics shown in the Figure sometimes or more often in the last year were classified as "yes." Physicians who rarely or never used any of the 3 tactics were classified as "no" (see "Methods" section of text).

†*P* values were calculated using the χ^2 test.

‡*P* values were calculated using the 2-tailed *t* test.

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Bivariate Analyses

Physicians who reported manipulating reimbursement rules were almost twice as likely to report patient requests to deceive third-party payers as those who did not (50.5% vs 27.2%; $P<.001$; TABLE 3). Physicians who agreed with the statement, "Today it is *necessary* to game the system to provide high-quality care" reported manipulating reimbursement systems more often than those who did not agree with the statement (64.3% vs 35.7%; $P<.001$). The mean score on the Hassle of Utilization Review scale was also significantly higher for those who reported manipulating reimbursement rules compared with those who did not (13.2 vs 12.4; $P<.001$). Perceptions of time pressure during office visits were positively correlated with physicians' decisions to manipulate reimbursement rules; those who reported using these tactics were less likely to agree with the statement that they have enough time with patients to get everything done that they needed to (35.8% vs 48.8%; $P<.001$). Physicians who manipulate reimbursement rules also reported a somewhat higher percentage of patients receiving Medicaid (20.6% vs 15.3%; $P = .002$), were less satisfied with their medical practice (51.6% vs 63.0%; $P = .003$), and felt less financially secure (40.4% vs 52.6%; $P = .002$) compared with physicians who reported rarely or never using these tactics. Those who reported manipulating reimbursement rules were less likely to agree that worry about prosecution for fraud would prevent them from exaggerating patients' conditions to third parties (42.3% vs 57.7%; $P = .04$). Other variables, including physician demographics (specialty, sex, rural practice, physician country of origin, and years of practice); primary payment by fee for service, capitation, or salary; physician income; and number of managed care contracts, were not

associated with manipulating reimbursement rules for patients (P>.20 for all).

Multivariate Analyses

In the multivariate model, a physician's belief that gaming the system is necessary to provide high-quality care remained the strongest predictor of manipulating reimbursement rules. As shown in TABLE 4, those who agreed with this statement were more likely to report having manipulated reimbursement rules compared with those who disagreed or were not sure (OR, 3.67; 95% confidence interval [CI], 2.54-5.29). Having patients who requested that physicians deceive third-party payers was also strongly associated with manipulating reimbursement rules, with those who received such requests being more likely to use these tactics (OR, 2.44; 95% CI, 1.72-3.45). Similarly, physicians who reported not having enough time with each patient had significantly higher odds of reporting manipulating reimbursement rules (OR, 1.69; 95% CI, 1.21-2.37), as did those with more than 25% of their patients covered by Medicaid (OR, 1.60; 95% CI, 1.08-2.38). Two negative findings from the multivariate model also merit mention. First, the physician's level of financial security was no longer related to physicians' manipulation of reimbursement rules (P = .11). Second, physicians who reported worrying about prosecution for fraud were not less likely to report manipulating reimbursement rules (P = .34).

Table 4. Results of Multivariate Logistic Regression Model Used to Determine Significant Factors Associated With Physicians' Reported Manipulation of Reimbursement Rules

Variables	Adjusted Odds Ratio	95% Confidence Interval
Today it is *necessary* to game the system to provide high-quality care*	3.67	2.54-5.29
Patients request that I deceive their third-party payer†	2.44	1.72-3.45
Not enough time with each patient*	1.69	1.21-2.37
More than 25% of patients covered by Medicaid	1.60	1.08-2.38

*Odds ratios compare those responding "agree" or "strongly agree" with those responding "disagree" or "strongly disagree."

†Odds ratios compare those responding "sometimes," "often," or "always" with those responding "rarely" or "never."

COMMENT

In this study of a nationally representative sample of physicians, we sought to determine how frequently physicians manipulate reimbursement rules to help their patients secure coverage for care that the physicians perceive to be necessary. Unlike previous studies, which have examined whether physicians might condone gaming the system under hypothetical circumstances,[9,13,17] we were interested in estimating how often physicians actually use deceptive tactics in the current health care system and whether certain factors might be increasing this frequency. We found that 3 different ways of manipulating reimbursement rules were all relatively uncommon but far from rare; between 10% and 27% of physicians reported using each tactic "sometimes" or more often in the last year to help patients obtain coverage. Added together, while the majority of physicians (61%) reported rarely or never exaggerating patients' severity of illness, changing patients' billing diagnoses, or reporting signs or symptoms that patients did not have in the last year, the rest (39%) reported using 1 or more of these tactics at least sometimes. In a multivariate model, the belief that gaming the system was necessary to get patients needed care, more requests from patients to deceive payers, believing that visit lengths were too short to get everything done that they needed to do, and having more than 25% of one's patients covered by Medicaid were independently and significantly associated with having manipulated reimbursement rules in the last year.

Physicians might manipulate reimbursement rules to benefit patients, themselves, or both. Since the financial

and health-related interests of patients and physicians can coincide, it is impossible to completely separate these motivations. However, 2 aspects of our findings suggest that financial self-interest is not the sole motivation for most physicians who manipulate reimbursement rules. First, manipulation of reimbursement rules was most common in the situation in which an individual physician could not possibly provide free or reduced-cost care (ie, hospitalization). Physicians may reserve gaming the system for situations in which free care cannot be offered. Second, to our surprise, we found no association between manipulation of reimbursement rules and any of the financial markers we examined, such as proportion of income at risk, principal type of reimbursement (fee for service vs capitation or salary), or recent practice-related income losses. Although the physician's perceived level of financial security was significant at the bivariate level, it was not significant in the multivariate model. Physicians with potentially greater financial stakes in manipulating reimbursement rules did not report doing so more often.

Not surprisingly, physicians who reported manipulating reimbursement rules were much more likely to believe that gaming the system is necessary to provide high-quality care today. Of perhaps more importance is that physicians who believed that gaming the system for patients is necessary were also significantly more likely to believe that it is ethically acceptable, indicating some degree of ethical adaptation to perceived necessity. However, even among physicians who reported that gaming is necessary, the majority still did not believe it is an ethical practice. This accords with the strongly worded official declarations of professional societies, wherein manipulating reimbursement rules is considered an ineffective and

socially irresponsible way to advocate for patients' interests.[18-20] These and other ethical arguments against gaming reimbursement systems are well developed.[5,8,18,19,21,22] Yet, although the AMA and others have consistently opposed the manipulation of reimbursement rules, regardless of intent, and though most physicians agree with this position, some nevertheless appear to view this advice as untenable given their immediate patient care obligations. Moreover, in the face of the current crackdown on fraud and abuse,[11,12] it is interesting that worry about prosecution for fraud did not seem to inhibit physicians from manipulating reimbursement rules to obtain coverage for needed care. Thus, neither ethical pronouncements nor further fraud and abuse enforcement are likely to be very effective in deterring manipulations of reimbursement rules among physicians who see it as the only feasible way to provide high-quality care.

Many physicians who reported manipulating reimbursement rules also reported receiving patient requests to deceive third-party payers. This suggests that both physicians and patients may not view current utilization review processes as legitimate or responsive to their needs. However, physicians could also be manipulating reimbursement rules in response to patient requests for another reason. Some might be deceiving insurers rather than confronting patients who present with unreasonable demands. Manipulating reimbursement rules may be easier and less time-consuming than attempting to explain to patients why a requested intervention is marginally beneficial or unnecessary, or exploring whether it could be paid for out-of-pocket by the patient.

Increasing time pressures have been linked to poorer health outcomes[23] and possibly increased malpractice

claims.[24] We found that feeling pressed for time is also associated with increases in manipulating reimbursement systems among physicians. This could reflect the time required to pursue regular advocacy routes, such as filing formal appeals. When time pressures make using regular advocacy routes inconvenient or impossible, physicians may be tempted to use covert advocacy tactics, such as manipulating reimbursement rules, to help their patients obtain needed care. We do not have information on the specific health plans in which manipulating reimbursement rules occurred and whether regular appeals processes were readily available, but manipulating reimbursement rules might be perceived to be the most rapid and convenient short-term way to obtain services in some situations.

It is not clear from these data why having more than 25% of one's patients covered by Medicaid is associated with a higher propensity to report manipulating reimbursement rules. Medicaid reimbursement rates are often lower than those of commercial payers, so accepting more Medicaid patients may put financial stresses on physicians that increase the perceived need to game the system to achieve target incomes. Some individuals are also more willing to mislead government entities than smaller exterprises.[25] Medicaid plans may also carry out more stringent or more intrusive utilization review, or patients covered by Medicaid simply may need more services and, hence, present more potential opportunities for physicians to manipulate reimbursement rules.

Although many physicians report manipulating reimbursement rules to help their patients obtain coverage for care that the physicians perceive to be necessary, the majority report doing so rarely or never. From these

data, we cannot tell whether this is because they did not have to or because they chose other avenues to obtain the care, or whether their patients did not receive needed care. The last scenario would be particularly worrisome for patients and their physicians, in part because current case law suggests that physicians are legally accountable for providing needed care and that they do not derive legal immunity by agreeing to accept health plan coverage rules.[26,27] That is, compliance with health plan rules does not provide protection against malpractice litigation and losses stemming from failure to provide an acceptable standard or care. Of course, failure to adhere to health plan coverage rules and manipulating these rules, even to benefit patients, also has potential legal repercussions.[10]

This study has several important strengths. We surveyed a random sample of physicians nationwide, including all specialties, and achieved a suitable response rate despite the controversial topic. For the first time that we are aware of, physicians were asked to report the frequency of actually manipulating reimbursement rules in practice. In previous studies, researchers have used second- or even third-party hypothetical scenarios to explore these behaviors.[9,13,14] While using hypothetical scenarios may be less threatening to respondents, it cannot address key issues in contention, such as whether these scenarios arise in practice and whether physicians really act as they say they might. Another strength is that we asked only about manipulating reimbursement rules to help patients obtain coverage for care that the physicians perceived to be necessary. While we cannot ascertain whether the physicians' judgments of medical necessity were accurate, we intentionally avoided issues of

large-scale fraud that the Health Care Financing Administration and others have primarily targeted, such as billing for services not rendered, kickbacks, and self-referral.[10] Most physicians oppose such activities, so they pose no real ethical dilemmas. Since we wished to address the frequency of physicians facing true ethical dilemmas due to reimbursement policies, the situations we addressed were intentionally ethically challenging, with no clear "right" answer.

There are several relevant study limitations. We could not independently confirm reported acts of manipulating reimbursement rules for patients. If there were a systematic reporting bias, however, we believe that it was in the direction of underreporting. Although we tried to frame the survey questions in neutral tones, the words *game* and *deception* were both used in some items and these words have negative connotations. Combining this socially desirable response bias with the perceived legal risk involved in admitting to using these tactics, it is likely that respondents underreported how often they manipulate reimbursement systems. A second limitation, with a similar underreporting bias, is that we only asked about 3 general ways in which physicians might manipulate reimbursement rules to help patients obtain care. It is likely that there are other ways of manipulating reimbursement rules that we did not address.

There are no simple solutions to the problem of physicians manipulating reimbursement rules for their patients. The root causes of this problem are tensions that are structural, largely unavoidable, and likely to become increasingly intense. These tensions reflect an underlying uncertainty as to whether health care is best viewed in a market-based contractual model or a profession-based

fiduciary model, when both models have ethical and legal strengths. A contractual model of health care, wherein patients and physicians are closely held to their written agreements with health plans and insurers, supports the compelling ethical principle of contractual justice.[28] And American society is leaning strongly toward a market-oriented emphasis on value for money and free choice in health care. Patients with good information and options should "get what they pay for." On the other hand, physicians traditionally act as their patients' agents (fiduciaries) and strive to provide an equally high standard of care to all, regardless of what individual patients can afford to pay.[29] It is well-known that many patients are not "good" health care consumers,[30,31] and can unwittingly agree to or be assigned to contracts that may not fully serve the r medical needs. Bending the rules for patients to provide a high-quality standard of care may be seen as an act of beneficence, or mercy, which is also ethically compelling.[32] While insurance policies are contracts between patients and insurers, our findings suggest that some physicians believe that strictly enforcing these contracts is contrary to their professional role as patients' agents and caregivers.

Physicians are thus caught in 2 sets of conflicting demands. Legally, physicians are contractually bound to adhere to reimbursement policies yet are also liable for failure to deliver an equally high standard of care to all patients, regardless of ability to pay. Ethically, physicians are caught between the compelling principles of social justice on the one hand and beneficence, or mercy, on the other. We can document the effects of these tensions and perhaps find ways to alleviate them, but the question no

empirical study can answer is, "When, if ever, is it 'good' for a contract to be broken in a surreptitious act of mercy?"

Without answering this question, our findings still have several practical implications. As pressures to control health care costs increase, it is likely that manipulating reimbursement systems will increase in parallel. Efforts to more tightly control utilization will likely increase physicians' perceived need to manipulate reimbursement rules to provide high-quality care and will increase patients' requests for the services being controlled. Further attempts to reduce physician reimbursement will put pressures on physicians to increase patient volumes, necessarily reducing the time physicians and patients spend with each other. Our findings suggest that such conditions will be associated with more covert manipulation of reimbursement rules, and that enforcement of fraud and abuse statutes will not alleviate this. On the other hand, possible approaches to minimize the perceived need for physicians to manipulate reimbursement rules might include providing adequate time for patient-physician discussions and involving physicians and patients in benefits determinations and utilization review processes. In our view, making utilization review procedures more user-friendly might encourage patients and physicians to use legitimate advocacy channels. Physicians and patients who are positively disposed to a utilization review system and who view its processes as legitimate, responsive, and non-punitive might be less tempted to manipulate it covertly for their own benefit. But attaining this goal must involve patients and physicians becoming committed to the social systems through which coverage decisions are made and overcoming their apparently high levels of cynicism regarding the effectiveness and fairness

of these systems today. Finally, as a market for systemic problems, evolving systems of care delivery could be individually assessed for their effects on physicians' perceived need to covertly manipulate reimbursement rules to provide high-quality care. Health plans in which the use of these tactics is common should carefully review their rules and procedures and work with physicians to reduce the perceived need for covert advocacy.

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PRACTICING LAWYER

Psychotherapist testimony in PI cases: coping with the stealth evaluation

by Eric G. Mart

It is only in recent years that the serious and sometimes chronic negative effects of psychological trauma have come to be recognized by the mental health professions. For decades, trauma-related symptoms were thought to be the result of intrapsychic conflicts and unconscious processes. In the last decade, however, mental health professionals have begun to recognize and understand the effects of both chronic and acute trauma. Patients who in an earlier time would have been diagnosed as having borderline personalities, depressive neuroses or phobias are now seen as suffering with conditions resulting from their traumatic experiences.

In the face of this new understanding, the legal system has changed the way in which injuries are compensated. In addition to punitive damages and compensation for pain and suffering and loss of income, courts have begun to allow compensation for the intentional or negligent infliction of psychological distress. Claims for

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emotional distress have become common, both as a component of personal injury cases and as the sole basis for actions.

Unfortunately, not all claims for compensation are valid, and the legal system's recognition of psychological trauma has opened the door for cases of dubious merit. Post Traumatic Stress Disorder, for example, has become the "junk back" of the 90s. The symptoms of PTSD are widely known and relatively easy to malinger. While many individuals are genuinely traumatized by experiences beyond normal human experience, a certain percentage of psychological trauma claims are false.

Bona fide vs. bogus claims

The court's problem of sorting through psychological damage claims to separate the bone fide from the bogus is complicated by certain types of expert testimony of mental health professionals, what I have heard referred to as the "stealth evaluation." Understanding the difference between this type of testimony and legitimate testimony requires some explanation.

In most jurisdictions, the testimony of a mental health professional is required in order to authenticate claims of psychic trauma. This means that a mental health professional who is qualified by the court must testify that the plaintiff is traumatized and that the proximate cause of the trauma was the act of negligence or malice in question. The assessment of this type of trauma by a forensic psychologist or psychiatrist is a complex undertaking, requiring specialized assessment skills, techniques and training.

Even with the aid of these skills, the diagnosis of bone fide trauma and assessment of proximate cause is a challenging task.

The stealth evaluation is often an attempt to circumvent this process while increasing the probability that the psychic damage claim will be seen as bone fide. After hearing the plaintiff's version of the alleged traumatic events, the plaintiff's attorney suggests that therapy is needed to help the plaintiff cope with the traumatic experiences and symptoms. The plaintiff sees a therapist for some length of time for therapy before the trial. At the trial, the therapist testifies that the plaintiff has symptoms consistent with PTSD and that the cause of these symptoms was more likely than not the actions or negligence of the defendant.

Advocacy or assessment?

What makes this a stealth evaluation? It is the fact that it is not an evaluation at all, but rather advocacy masquerading as assessment. Assessment and diagnosis are processes in which all plausible hypotheses are formulated and then rigorously investigated to see which one best fits the data. In any case involving the negligent or intentional infliction of psychological distress, there are at least four logical possibilities to explain the plaintiff's symptomatic presentation:

- the symptoms are bone fide and are directly related to the alleged traumatic events
- the symptoms are present but exaggerated
- The symptoms are falsely imputed to the alleged traumatic incident. That is, a patient has genuine

symptoms, but they may have existed before the alleged incident and are now being attributed to the incident which is the basis of the lawsuit.

- the symptoms are malingered

Differing evaluations

In a forensic evaluation, the mental health professional who performs the assessment examines each possible explanation for the patient's symptomatic presentation. Data is collected and each hypothesis is weighed in the light of supportive and disconfirming data. None of the possibilities should be given precedence in the initial stages of the process. At some point, the evaluator forms an opinion and uses the data to support his or her formulation in court.

When psychotherapist testimony is used to establish the presence of psychological injury, the circumstances are very different. In virtually every case, the patient presents his or her history and symptoms to the therapist, who generally accepts the account at face value. No attempt is made to test or disconfirm the implicit hypothesis that the patient's account of events is accurate. The basis of successful psychotherapy is a trusting relationship between therapist and client. Since any attempt by a therapist to verify or disconfirm the patient's version of events would probably destroy this trust, treating therapists rarely attempt to assess the possibility of false imputation or malingering.

Psychotherapy becomes a stealth evaluation when the therapist's impressions of the client's mental state and the proximate cause for these symptoms are presented in

court as though they constituted a forensic evaluation. This type of testimony has a certain logic or face validity that can appeal to a jury that may assume the treating therapist knows the patient well and is in a position to understand the case. The difference between an evaluation and psychotherapy may be difficult to explain to a jury of laymen.

Helpful strategies

There are several strategies which may prove helpful in dealing with this problem. One is to become familiar with the ethical standards and guidelines for psychologists which govern forensic activities. Section 7.02(a) of the Ethical Principles of Psychologists and Code of Conduct states that, "Psychologists' forensic assessments, recommendations and reports are based on information and techniques (including personal interviews of the individual where appropriate) sufficient to provide appropriate substantiation for their findings." This means that treating therapists who testify that their clients have been traumatized by defendants' alleged actions or negligence may actually be acting unethically if they have not made efforts to corroborate the stories, substantiate the existence of symptoms, or rule out symptom exaggeration, malingering and false imputation.

Additionally, section 7.02(b) states that, "Except as noted in (c), below, psychologists provide written or oral forensic reports or testimony of the psychological characteristics of an individual only after they have conducted an examination of the individual adequate to support their statements or conclusions." Finally, section 7.02(c) states that "When, after reasonable efforts, such an examination

is not feasible, psychologists clarify the impact of their limited information of the reliability and validity of their reports and testimony, and they appropriately limit the nature and extent of their conclusions and recommendations."

It should be noted that this last admonition appears to impose an affirmative obligation on the psychologist testifying in these cases. When the only source of data has been the patient's self-report and the therapist's observations during therapy sessions, it is not enough to respond honestly to questions about methodology. The therapist must make the limitations of his or her data clear by prefacing any remarks with a statement such as: "Let me say before I begin that I am basing my conclusions entirely on my patient's version of the events and description of symptoms. I made no attempt to assess the veracity of this version of the events, nor did I attempt to rule out malingering or symptom exaggeration." Failure to do this may be unethical.

Share research with judges, jury

It is probably also a good idea to educate the judge and jury about the techniques available for the assessment of these issues. There is a substantial body of empirical research devoted to these types of assessments. While these studies are sometimes contradictory, it is clear that there are protocols, procedures and tests which can – and should – be employed in psychological injury assessments. These techniques are rarely used by treating therapists. Making it clear that these techniques are readily available, but were not utilized, can further undermine any

unwarranted conclusions put forward in the therapist's testimony.

Finally, many confident psychotherapists will attempt to brush these concerns aside and claim that their experience and clinical judgment make it possible for them to draw diagnostic conclusions that are reliable and valid. In these cases it is important to be familiar with the extensive literature on the lack of reliability of clinical judgment. There is a great deal of empirical evidence which makes it clear that clinical judgment is notoriously unreliable, particularly when malingering and deception may be involved.

Of particular interest is research that makes it clear that individuals generally thought to have the ability to detect lying and deception, such as psychologists, psychiatrists, judges and police officers, are no better than anyone else at spotting deception. Particularly surprising is the fact that the confidence they attribute to their judgments about deception has no relation to the correctness of these judgments.

Counteracting testimony

Making this information available to the judge or jury in a case can go a long way toward counteracting unsubstantiated therapist testimony. It has been my experience that most attorneys, judges and, regrettably, most psychologists, are unaware of the implications of the ethical standards and guidelines governing forensic activities for psychologists. However, these guidelines are logical, and they help to counter the seemingly logical position that the psychotherapist is in the best position to understand and

testify about the existence and extent of a patient's symptoms.

One of the best ways to develop an appropriate cross-examination or deposition of the treating therapist is to obtain the services of an appropriately trained forensic psychologist to consult on the case, give rebuttal testimony, or both. The issues involved in these types of evaluations are certainly understandable to attorneys, but the ethical and methodological questions raised can be confusing and arcane. The assistance of an appropriately trained and experienced forensic psychologist can frequently be invaluable in countering "stealth evaluation" testimony.

Lying for Patients

Physician Deception of Third-Party Payers

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Background: Some physicians may resort to deception to secure third-party payer approval for patient procedures. Related physician attitudes, including willingness to use deception, are not well understood.

Objective: To determine physician willingness to deceive a third-party payer and physician attitudes toward deception of third-party payers.

Methods: A cross-sectional mailed survey was used to evaluate physician willingness to use deception in 6 vignettes of varying clinical severity: coronary bypass surgery, arterial revascularization, intravenous pain medication and nutrition, screening mammography, emergent psychiatric referral, and cosmetic rhinoplasty. We evaluated 169 board-certified internists randomly selected from 4 high- and 4 low-managed care penetration metropolitan markets nationwide for willingness to use deception in each vignette.

Results: Physicians were willing to use deception in the coronary bypass surgery (57.7%), arterial revascularization (56.2%), intravenous pain medication and nutrition (47.5%), screening mammography (34.8%), and emergent psychiatric referral (32.1%) vignettes. There was little willingness to use deception for cosmetic rhinoplasty (2.5%). Rates were highest for physicians practicing in predominantly managed care markets, for clinically severe vignettes, and for physicians spending less time in clinical

practice. Physician ratings of the justifiability of deception varied by perspective and vignette.

Conclusions: Many physicians sanction the use of deception to secure third-party payers' approval of medically indicated care. Such deception may reflect a tension between the traditional ethic of patient advocacy and the new ethic of cost control that restricts patient and physician choice in the use of limited resources.

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IN THE past decade, managed care programs have increased their role in the daily practice of medicine.[1] Physicians have experienced pressure from managed care organizations (MCOs) to reduce utilization and curtail costs. Practice controls such as utilization restraints and preapproval criteria have limited physician autonomy.[2-5] As MCOs impose stricter controls on access to specific medical treatments, physicians are increasingly facing an ethical dilemma – how to reconcile their professional responsibilities as patient advocates with potentially conflicting contractual obligations to third-party payers.

Anecdotal evidence [6-9] suggests that some physicians have chosen to maintain the appearance of compliance while skirting managed care guidelines in order to secure treatment. Such deception, primarily in the form of incorrect or ambiguous documentation, has been called "gaming the system."[10] However, the full extent to which physicians support the deception of third-party payers, particularly for which clinical indications, remains unknown. Furthermore, physicians' attitudes and beliefs about the use of deception are not well characterized. We report the results of a study investigating physicians' attitudes toward the deception of third-party payers, and identify clinical and demographic patterns associated with the sanctioning of deception.

STUDY VIGNETTES

CORONARY BYPASS SURGERY

A 55-year-old woman presents to a colleague as a new patient seeking referral for coronary revascularization (coronary artery by-pass graft [CABG]). She is homebound because of angina. A recent angiogram indicated severe 3-vessel coronary occlusion that appeared amendable to CABG. However, she was recently forced to switch insurance companies. She remains stable but is receiving a maximal medical regimen. She reports occasional severe angina symptoms relieved by sublingual nitroglycerin administration, but there has been no progression in her chest pain symptoms. Based on a medical literature review, your colleague understands that CABG is medically indicated for such a debilitating and life-threatening condition, yet knows that the patient's third-party payer will not pay for CABG for this preexisting condition unless she has progressive chest pain. Thus, the patient can forgo

CABG or have it at her own expense. However, your colleague also knows that the third-party payer will pay for coronary revascularization if he or she documents "increased frequency of chest pain" as an indication for coronary revascularization, even though such documentation would not be accurate.

PARTICIPANTS AND METHODS

We developed a survey instrument to assess physicians' attitudes toward the deception of third-party payers as a means of securing patient treatment. Our intent was to present physicians with clinical vignettes that a primary care physician might face in practice, and to evaluate their willingness to sanction the use of deception and their attitudes about deception for each vignette. The survey was distributed to internists in 4 regions of the Untied States. We initially developed 10 vignettes of varying clinical severity and pilot tested the survey instrument among physicians in an internal medicine group at an academic health center. Based on follow-up interviews and analysis of responses, 6 vignettes that covered a range of clinical severity were selected and further refined for the final survey instrument.

Physicians were presented with clinical vignettes in which a colleague was considering deceiving a third-party payer to secure treatment for a patient. The use of questions framed for another agent committing a potentially unethical act is an accepted method for eliciting respondent perceptions.[11] Physicians were informed that for each vignette, (1) the patient is seeking only the specific procedure or referral discussed; (2) the patient cannot afford the procedure or referral on his or her own because of financial

hardship, and no external resources are available; (3) local colleagues are unwilling to provide services unless they are reimbursed; (4) despite diligent efforts by the physician and colleagues, the patient's third-party payer is unwilling to change its reimbursement policy regarding the particular procedure or referral; and (5) the third-party payer checks documentation but does not confirm clinical findings.

To evaluate physician support for the use of deception, we employed a conceptual framework based on casuisty.[12] Casuistic analyses begin with a paradigm case and then modify aspects of the case to determine whether changes in the details of the case modify judgments about the morality of the action. In our analysis, we varied the clinical severity and risks associated with the patient's condition between vignettes. Vignettes ranged from life-threatening (arterial revascularization and coronary bypass graft) to emergent (psychiatric referral), palliative (intravenous pain medication and nutrition), diagnostic (mammography), and cosmetic (rhinoplasty). In each vignette, physicians were asked whether their colleague should deceive the third-party payer. Physicians were then asked how they, their colleagues, and society would rate the physician's deceptive behavior on a 5-point Likert scale ranging from 1 (clearly justified) to 5 (clearly unjustified) (see "Study vignettes" section).

Respondents also provided demographic data, practice characteristics, and career and professional perceptions. Demographic data included physician age, sex, and race or ethnic affiliation. Practice characteristics included years since completion of residency, years practicing in the current metropolitan market, percentage of time devoted to direct clinical care, payer mix (percentage of patients

enrolled in Medicare, enrolled in Medicaid, capitated, self-pay, or uninsured), type of clinical income (salaried or nonsalaried), and type of practice setting (academic health center, staff health maintenance organization [HMO], solo practice, or group practice with number of associates). Career and professional perception items evaluated agreement with statements concerning satisfaction with a medical career, opportunity to practice quality medical care, professional autonomy, business aspects of practice, and relationships with colleagues.[13] Physicians were also asked to select 1 of 5 statements characterizing their primary professional responsibility.

STUDY SAMPLE

To determine what role practicing in a predominantly managed care market might have on physician attitudes, we identified 4 metropolitan markets in the Untied States with a high level of managed care penetration. We defined a high-managed care penetration market as a market in which 40% or more of the total metropolitan area population was enrolled in an HMO. Results of prior research[14] have shown that HMO penetrations greater than 30% result in a significant HMO effect on provider and purchaser communities – affecting product diversity, premiums, provider reimbursement, and most important, health system organization. We also identified a low-managed care penetration market in each of the same regions, in which less than 25% of the population was enrolled in an HMO. Metropolitan area managed care penetration figures and populations were obtained from the 1995 Interstudy Competitive Edge Regional Market Analysis 6.1 and reflect market data as of July 1, 1995.[14]

From the list of potential candidate metropolitan areas, we identified high- and low-managed care penetration markets in each region that were most similar in population. We then selected the largest such pairing for inclusion in the study. The high-penetration markets selected (and their respective managed care penetrations and study regions) were Boston, Mass (42.1%, Northeast); Miami, Fla (43.6%, South); Minneapolis – St. Paul, Minn (42.0%, Midwest); and San Francisco, Calif (42.1%, West). The low-penetration markets selected (and their respective managed care penetrations and study regions) were Pittsburgh, Pa (24.2%, Northeast); Atlanta, Ga (16.1%, South); St. Louis, Mo (22.7%), Midwest); and Las Vegas, Nev (20.9%, West). Sample physicians were divided among these 8 metropolitan markets, based on the size of the local population.

We further modified our sample to assess sex effects by quota sampling within each metropolitan region to provide maximal power for sex comparisons. The vignettes were presented to half of the sample in order of increasing clinical severity, and in reverse order to the other half to test for order effects. We limited our sample to physicians exclusively board certified in internal medicine. Physicians were randomly drawn from metropolitan market listings in the 1996 American Board of Medical Specialties Directory of Board Certified Medical Specialists.[15] Physicians who had board certifications in fields other than internal medicine, had completed subspecialty fellowship training (with the exception of general medicine fellowships), or were no longer active in clinical practice were excluded from analysis and replaced with a randomly selected physician of the same sex from the same metropolitan market.

Sample physicians were initially contacted by mailed questionnaire in December 1996. Physicians with incorrect addresses were followed up by local directory assistance where possible. After the start of the study, nonresponders were followed up by 2 additional survey mailings at 1 and 3 months, 2 follow-up telephone calls at 2 and 4 months, and a facsimile transmission of the survey instrument at 6 weeks. All surveys were identified by a unique identification code to ensure confidentiality of responses. Study protocol, methods, and survey instrument were approved by Georgetown University Medical Center's institutional review board, Washington, DC.

DATA ANALYSIS

The primary outcome of interest was physicians' sanctioning of a colleague's deception of the third-party payer in each of the 6 vignettes. The effect of clinical severity on the sanctioning of deception was evaluated by the Cochran Q test and McNemar tests of deception rates in each vignette. We also tested for an association between support for deception and other variables – demographics, practice characteristics, and perceptions of career and professional responsibilities. Physician's reported personal, collegial, and societal justifications of deception in each vignette (reported on a 1- to 5-point Likert scale) were evaluated by a 3 (personal, collegial, and societal perspectives) X 6 (vignette) repeated-measures analysis of variance. A significant interaction effect was followed up using tests of simple effects by the Tukey Honestly Significant Difference test for paired differences. Perceived primary professional responsibility and career satisfaction items are also reported. Categorical variables were compared with the X^2 test and expressed in proportions.

Continuous variables were compared using an independent sample *t* test analysis. Statistical analysis was performed with 2 software packages (SAS 6.11; SAS Institute Inc, Cary, NC, and Statistica; StatSoft Inc, Tulsa, Okla).

ARTERIAL REVASCULARIZATION

A 55-year-old woman presents to a colleague as a new patient seeking referral for arterial bypass grafting for chronic arterial insufficiency to her foot. She has never smoked but has chronic, arterial insufficiency secondary to chronic atherosclerotic disease. She is in pain "at rest," and has chronic nonhealing ulcers. Physical examination reveals pregangrenous skin changes that the patient reports existed before her current insurance coverage began. Based on a medical literature review, your colleague understands that arterial revascularization is medically indicated to avoid later amputation of the toes or foot. Your colleague knows that the patient's third-party payer will not pay for arterial revascularization if the pregangrenous changes were a preexisting condition, which leaves her to forgo the arterial revascularization or have the procedure at her own expense. However, your colleague also knows that the third-party payer will pay for arterial revascularization if he or she documents "new skin changes: pregangrenous" as an indication for arterial revascularization, even though such documentation is inaccurate.

INTRAVENOUS PAIN MEDICATION AND NUTRITION

A 55-year-old woman presents to a colleague as a new patient seeking referral for intravenous pain medication

and nutrition as part of her comfort care at home. She has been diagnosed with incurable ovarian cancer, and is not expected to live long. She has chronic abdominal pain that is relieved only by taking oral pain medication. She also has severe, refractory nausea for 1 to 2 hours after swallowing solids or liquids. All antinausea drugs have failed to provide any relief. She reports no vomiting and no problems swallowing. Based on a medical literature review, your colleague understands that intravenous pain medication and nutrition are medically indicated as part of comfort care for a patient with such a terminal condition, yet knows that the patient's third-party payer will not pay for comfort care as long as she is still able to swallow solids and liquids without vomiting, leaving her to forgo intravenous treatment (and continue taking oral medication and nutrition), or receive it at her own expense. However, your colleague also knows the the third-party payer will pay for intravenous pain medication and nutrition as part of comfort care if he or she documents "recurrent vomiting" as the indication for intravenous pain medication and nutrition, even though such documentation would not be accurate.

PSYCHIATRIC REFERRAL

A 55-year-old woman presents to a colleague as a new patient seeking referral for psychiatric treatment for depression. She notes that the physician who was caring for her died unexpectedly, and that she has been unable to get further information or referrals through his office. She claims a recurrent history of profound depression and cites several past suicide attempts, revealing well-healed scars down both writs. She presents her prescription medication

bottles and claims compliance with a maximal antidepressant therapy regimen for more than 3 months. She reports a 3-week history of daily feelings of profound sadness, guilt, and worthlessness. She has had no interest in regular activities, great difficult concentrating, and feels completely estranged from her family. In addition, she reports fatigue, insomnia, little appetite, and a 15% loss in body weight during the past 3 weeks. She is tearful, agitated, and concerned that she is feeling worse with each passing day. She strongly denies suicidal or homicidal ideation. She is cooperative and even willing to be hospitalized – but only if her insurance will cover the costs. Based on a medical literature review, your colleague understands that urgent psychiatric referral is medically indicated, yet knows that the patient's third-party payer will not pay for psychiatric referral unless she states an intent or exhibits demonstrable evidence of imminent suicidal or homicidal behavior. However, your colleague also knows that the third-party payer will pay for a psychiatric referral if he or she documents "patient states suicidal ideation" as an indication for the psychiatric referral, although such documentation would not be accurate.

MAMMOGRAPH SCREENING

A 55-year-old woman presents to a colleague as a new patient seeking referral for a mammogram. Her younger sister was recently diagnosed with breast cancer. The patient has never had a mammogram but is concerned that she too may have breast cancer. She has not noted any new breast lumps, skin changes, or nipple discharge. Your colleague's physical examination reveals no evidence

of any breast lumps or lesions. Based on a medical literature review, your colleague understands that an annual screening mammogram is medically indicated for women older than 50 years, especially if they have a family history of breast cancer. Your colleague knows that the patient's third-party payer will not pay for a screening mammogram, leaving the patient to forgo screening or have it at her own expense. However, your colleague also knows that the third-party payer will pay for a mammogram if he or she documents "suspicious breast lump" as an indication for the mammogram, even though such documentation would not be accurate.

COSMETIC RHINOPLASTY

A 55-year-old woman presents to a colleague as a new patient seeking referral for rhinoplasty (the surgical alteration of nasal bones). She has no significant medical history and currently has no medical complaints. However, she is sad about feeling less attractive with each passing year. In addition, she becomes tearful when recounting how she has been teased throughout her life about having a prominent nose. She is realistic in not expecting changes in her nose to radically change her life, but she would like to improve this one feature of her body. She denies any injury to her nose and reports no problems breathing. Based on a medical literature review, your colleague understands that rhinoplasty is not medically indicated but would certainly make the patient feel better about herself. Your colleague knows that the patient's third-party payer will not pay for rhinoplasty as an elective procedure, leaving the patient to forgo the procedure or have it at her own expense. However, your colleague

also knows that the third-party payer will pay for rhinoplasty if he or she documents "deviated septum, problems breathing" as an indication for the surgery, even though such documentation would not be accurate.

RESULTS

Of 602 randomly selected physicians, we obtained accurate contact information for 471. A further 18 physicians were excluded because of retirement from practice or having moved out of the sample area, and they could not be replaced by random sampling. At the conclusion of data collection in June 1997, we received 169 responses (37.3% of contacted physicians). Respondents and nonrespondents did not differ by sex, age, or years in practice.

Respondents were predominantly women (52.7%) and white (81.7%), with a mean age of 41.6 years. Most respondents were salaried (78.1%) and located in high-managed care penetration markets (56.85%). A total of 40.8% practiced at academic medical centers. On average, respondents spent 69.4% of their time in clinical work, had been in practice 10.1 years after residency, and had spent 9.3 years in their current metropolitan market (**Table 1**).

Table 1. Physician (N = 169) Demographics

Demographic	Physicians
Women, %	52.7
Age, mean, y	41.6
White, %	81.7
Practice characteristics	
Clinical time, mean, %	69.4
Practice after residency, mean, y	10.1
Practice in current metropolitan market, mean, y	9.3
Salaried, %	78.1
Practice setting, %	
Academic health center	40.8
Staff health maintenance organization	8.3
Solo practice	10.1
Group practice	37.3
Study region, %	
Northeast	33.2
South	20.7
Midwest	30.6
West	15.4
High–managed care penetration	56.8

SANCTIONING DECEPTION

Our principal analysis was a determination of physician support for deception of a third-party payer to secure patient treatment (**Table 2**). Most physicians sanctioned deception to obtain authorization for coronary bypass surgery (57.5%) and arterial revascularization (56.2%). Many physicians also approved deception to obtain intravenous pain medication and nutrition (47.5%), mammography (34.8%), and psychiatric referral (32.1%). Few physicians supported deception for cosmetic rhinoplasty (2.5%). More than a quarter of physicians (26.6%) did not support deception in any vignette, whereas 13.6% sanctioned deception in all vignettes except cosmetic rhinoplasty.

Sanctioning of deception was associated with clinical severity of vignettes (Cochran Q = 200.25; $P<.001$). McNemar tests indicated that sanctioning of deception decreased as clinical severity decreased (Table 2). In other words, the deception rates for each vignette are arranged in descending order as follows: (coronary artery bypass ~ arterial revascularization) > intravenous pain medication and nutrition > (psychiatric referral ~ mammography) > cosmetic rhinoplasty.

Analysis of deception by practice location identified significant variation. Physicians practicing in high-managed care penetration markets were more likely to sanction deception in arterial revascularization (64.1% vs 45.7%; $P = .02$) and mammography (44.1% vs 22.5%; $P = .004$) vignettes. These physicians also provided higher rates of deception approval for all other vignettes, including cosmetic rhinoplasty, although differences were not statistically significant (psychiatric referral, $P = .10$; intravenous pain medication and nutrition, $P = .18$; CABG, $P = .28$; and cosmetic rhinoplasty, $P = .008$).

Physicians who sanctioned deception spent less time in clinical practice than those who did not. In the arterial revascularization vignette, physicians sanctioning deception reported spending 64.8% of their time in clinical practice compared with 75.4% who did not (P = .04). Percentage of clinical time was also lower for physicians who sanctioned deception in intravenous pain medication and nutrition (61.5% vs 78.0%; P = .001), psychiatric referral (61.1% vs 74.2%; P = .02), and mammography (57.8% vs. 76.5%; $P < .001$) vignettes. Clinical experience, as evaluated by years in practice after residency, was not associated with deception in 5 of 6 vignettes; physicians suggesting deception for psychiatric referral had been in practice significantly longer (13.4 vs 8.5 years; P = .02). Practice setting was not associated with sanctioning of deception in 5 of 6 vignettes; physicians practicing at academic health centers trended toward greater sanctioning of deception in the mammography vignette (42.6% vs 28.6%; P = .06).

Sanctioning of deception was not associated with physician sex in any vignette. Physician race and age were also not associated with sanctioning of deception, although both trended toward significance in the mammography (P = .05) and psychiatric referral ($P < .06$) vignettes. Analysis of demographic differences in rates of deception, however, were limited because of low statistical power. In addition, the order of vignettes was not associated with differences in deception attitudes. Because of the low proportion of physicians sanctioning deception in the cosmetic rhinoplasty vignette, we could not evaluate demographic or practice effects for this case. Comparisons of deception sanctioning by demographic and practice characteristics are provided in **Table 3** and **Table 4**

Table 2. Physician Deception and Deception Ratings by Vignette

	Vignette					
	Coronary Bypass Surgery	Arterial Revascularization	Intravenous Pain Medication and Nutrition	Psychiatric Referral	Mammography	Cosmetic Rhinoplasty
Deception rate*	57.7[a]	56.2[a]	47.5[b]	32.1[c]	34.8[c]	2.5[d]
Justifiability of deception ratings†						
Self	2.4[e]	2.4[e]	2.7[e]	3.0[e]	3.1[e]	4.3[e]
Colleagues	2.3[e]	2.3[e,f]	2.5[e]	2.8[e,f]	2.7[f]	3.8[f]
Society	2.2[e]	2.2[f]	2.2[f]	2.7[f]	2.6[f]	3.8[f]

**Vignettes with different superscript letters have significantly different ($P<.05$) deception rates: (coronary artery bypass ≈ arterial revascularization) > intravenous pain medication and nutrition > (psychiatric referral ≈ mammography) > cosmetic rhinoplasty.*

†Mean justifiability ratings within each vignette with different superscript letters are significantly different from each other ($P<.05$). Support for deception is evaluated using a 5-point Likert scale ranging from 1 (clearly justified) to 3 (neither justified nor unjustified) to 5 (clearly unjustified).

JUSTIFIABILITY OF DECEPTION

Physicians rated the use of deception as most justified for a patient requiring coronary bypass surgery and arterial revascularization, and least justified for a patient requesting cosmetic rhinoplasty. A repeated-measures analysis of variance of the justificability of deception ratings indicated a significant interaction between clinical vignette and perspective ($F_{10,1510} = 5.64$; $P < .001$). Analysis of simple effects showed several patterns. First, there were significant differences in physicians' reported justifiability ratings from the 3 perspectives for 5 clinical vignettes. In only the coronary artery bypass vignette did respondents believe that they, colleagues, and society would agree on the justificability of deception. Second, physicians consistently assumed that society would provide greater justification ratings than they would. Third, physicians assumed that they and colleagues would provide comparable justifiability ratings for the 4 more severe vignettes. Physicians were somewhat less tolerant of a deceptive act than they believed their colleagues might be for the mammography and cosmetic rhinoplasty vignettes. Finally, differences between physicians' reported colleague and society justifications were found only in the intravenous pain medication and nutrition vignette. Justification ratings for deception were comparable in all other vignettes.

Ratings of the justifiability of deception paralleled variations in the sanctioning of deception associated with managed care markets. Physicians practicing in high-penetration markets reported significantly greater acceptance of deception than those practicing in low-penetration markets in the arterial revascularization vignette (2.2 vs 2.7; $P < .05$). Greater physician justification of deception in high-penetration markets was also reported in the

coronary bypass graft (2.2 vs 2.6), psychiatric referral (2.8 vs 3.2), and mammography (2.8 vs 3.4) vignettes ($P < .05$ for all).

The high rates of sanctioning of deception were consonant with physicians' reported professional obligations. Most physicians (76.4%) believed their primary professional responsibility was to practice as their "patient's advocate; working within the rules and restrictions of third-party payers, so long as those rules do not significantly compromise my patient's interests." Physicians reporting patient advocacy as a primary responsibility were more likely to sanction deception for arterial revascularization (62.1% vs 25.0%; $P = .001$), coronary bypass (63.2% vs 29.2%; $P = .02$), intravenous pain medication and nutrition (53.7% vs 23.1%; $P = .005$), and mammography (37.1% vs 24.8%; $P = .03$). Physicians sanctioning deception in the psychiatric referral vignette reported significantly greater dissatisfaction ($P = .002$) with their degree of professional autonomy; dissatisfaction with professional autonomy was not associated with sanctioning of deception in other vignettes. Sanctioning of deceptive behavior was unrelated to other measures of career satisfaction. Professional responsibility and career perceptions are reported in **Table 5**.

Table 3. Sanctioning of Deception by Demographics and Practice Characteristics*

	Coronary Bypass Surgery	Arterial Revascularization	Intravenous Pain Medication and Nutrition	Psychiatric Referral	Mammography
HMO market penetration, %					
High	61.3	64.1	52.2	37.4	44.1
Low	52.9	45.7	41.4	25.4	22.5
P	.28	.02	.18	.10	.004
Sex, %					
Male	55.8	54.6	46.7	36.4	36.4
Female	59.3	57.6	48.2	28.2	33.3
P	.66	.69	.84	.27	.68
Race, %					
White	54.9	53.3	45.0	32.6	31.3
Minority	70.0	56.8	58.6	30.0	50.0
P	.13	.73	.18	.78	.052
Practice location, %					
Academic center	58.8	57.4	54.6	31.8	42.6
Elsewhere	57.8	55.6	42.7	33.0	28.6
P	.9	.82	.14	.88	.06
Income, %					
Salaried	57.0	56.2	46.8	29.7	35.7
Nonsalaried	58.1	53.3	44.8	43.3	26.7
P	.92	.77	.85	.15	.35

**HMO indicates health maintenance organization.*

Table 4. Sanctioning of Deception by Practice Characteristics and Demographics*

	Deception		
	Sanctioned	Did Not Sanction	P<
Coronary artery bypass graft			
Age, y	41.6	41.2	.80
Clinical time, %	66.8	73.5	.20
Years in practice	9.9	10.3	.83
Years in sampled market	8.9	9.9	.47
Arterial revascularization			
Age, y	41.4	41.6	.93
Clinical time, %	64.8	75.4	.04
Years in practice	9.9	10.4	.79
Years in sampled market	8.9	9.8	.49
Intravenous pain medication and nutrition			
Age, y	41.1	41.6	.75
Clinical time, %	61.5	78.0	.001
Years in practice	9.7	10.1	.77
Years in sampled market	8.8	9.7	.52
Psychiatric referral			
Age, y	43.7	40.3	.06
Clinical time, %	61.1	74.2	.02
Years in practice	13.4	8.5	.006
Years in sampled market	10.9	8.6	.11
Mammography			
Age, y	41.0	41.4	.79
Clinical time, %	57.8	76.5	.001
Years in practice	9.5	10.1	.76
Years in sampled market	8.4	9.6	.42

** Years in sampled market refers to number of years practicing in current city.*

COMMENT

In this study, many physicians sanctioned the use of deception to obtain medical care for a patient when denied authorization by a third-party payer. Sanctioning of deception varied by the clinical severity of a patient's condition, but deception was sanctioned by most physicians in our 2 most clinically severe vignettes. Physicians also reported high levels of justification for the deception of third-party payers. Because most physicians report that it is their duty to work as patient advocates within the rules of third-party payers until those rules compromise their patients' care, this underlying attitude may represent physicians' main justification for sanctioning deception and the view that deception is justifiable.

Although physician support for deception was high in the overall cohort, we noted significant variations between locations. Physicians practicing in high-managed care penetration markets were more likely to sanction deception than were those in other markets. Although only significant in 2 scenarious, physicians in high-penetration markets trended toward higher rates of deception in all clinical vignettes. A similar pattern was observed for physician ratings of the justifiability of deception, which were also higher in high-penetration HMO markets. Taken together, these data suggest that HMO market penetration affects physicians' willingness to sanction the use of deception. This finding is consistent with the hypothesis that, as managed care brings more restrictions to a market, physicians practicing in that market become more willing to support deception as a means of circumventing these restrictions.

We hypothesized that deception rates would be highest in vignettes of greatest clinical severity and immediate patient risk. The relative ranking of physician sanctioning of deception in the vignettes supports this hypothesis. Furthermore, physicians showed greater support for deception in life-threatening illness than in urgent care needs, and in cases of palliative and diagnostic care than in cosmetic care.

Table 5. Professional Responsibility and Career Perceptions

Statement	Agreement, %
Primary professional responsibility*	
Practice within the rules/restrictions of third-party payers with strict adherence to those rules to the best of my ability	4.3
Practice within the rules/restrictions of third-party payers as long as those rules do not significantly compromise my patients' interests	8.7
Practice in a way that equally balances my patients' interests with the rules/restrictions of third-party payers	8.7
Practice as my patients' advocate working within the rules/restrictions of third-party payers as long as those rules do not significantly compromise my patients' interests	74.5
Practice as my patients' advocate without regard to the rules/restrictions of third-party payers	3.7
Career perceptions	
I doubt that medicine is the right profession for me	21.1
My opportunity to practice quality medicine falls short of my expectations	32.7
My degree of professional autonomy falls short of my expectations	46.3
The business aspects of my practice are worse than I expected	50.6
My relationships with my colleagues are worse than I expected	0

**Categories of primary professional responsibility, as indicated by participants.*

Previous studies have documented physician willingness to use deception to secure medically indicated patient care. A survey[16] of physicians practicing in the North-east found that nearly 70% of respondents would knowingly misdocument a screening test as a diagnostic service to ensure coverage of service. Primary care physicians have historically misdocumented diagnoses to reduce the risk of patient stigmatization or insurance and employment discrimination.[17] However, results of recent studies[18] show that patient concerns about maintaining insurance coverage and ensuring continued access to care through service reimbursement have become more frequent reasons for deliberate miscoding. Similar uses of inaccurate documentation to secure patient care have been reported by other health care professionals.[19] In fact, an evaluation[20] of ethical dilemmas in outpatient practice identified patient cost considerations as the primary source of ethical problems arising from office visits.

The advent of managed care and increased reliance on utilization review has further restricted a physician's ability to practice independently, increasing patient and physician frustration.[21] These effects are logically felt most in markets where managed care has the greatest effect on health care delivery. Our data suggest that physicians in such markets are more willing to respond to managed care's restrictions by condoning deception. Physician deception in these markets might not even be limited to life-threatening vignettes but also used in other cases in which a physician believes a procedure is in the patient's best medical interests. This sentiment can reach extremes. That physicians who condoned deception to secure coverage for cosmetic rhinoplasty – the survey's only medically nonindicated vignette – were exclusively from high-managed care

penetration markets underscores the extent of this sentiment. Resistance to such practices may also explain physicians' unwillingness to cooperate with third-party payers in other areas, including disclosure of patient information[22] and suspected patient health insurance fraud.[23]

Both MCOs and professional societies are aware of this trend in physician behavior.[10,23-27] Managed care firms have responded to inaccurate claims by increasing the rigor of utilization review and terminating contracts with physicians suspected of using deception. Professional societies have standing guidelines that prohibit fraudulent misrepresentation in dealings with insurers. However, these guidelines are not fully developed. The American College of Physicians' Ethics Manual[25] states that physicians are not obligated to lie to a third-party payer for a patient, but it does not expressly condemn deception to obtain care. The American Medical Association's Council on Ethical and Judicial Affairs[26] and the Woodstock Theological Center[27] specifically enjoin physicians from using deception or gaming the system and instead, urge physicians to work through appeals processes at MCOs. Although President Clinton's recently announced *Patient Bill of Rignts* and similar Congressional efforts[28,29] might facilitate such appeals, patients' expectations of their physicians, coupled with MCOs' fundamental reliance on decreased use of services to reduce costs, suggests continued conflict and only minimal gains.

Although many physicians believed deception was appropriate in the face of restrictions on patient care, a large proportion also refused to sanction deception. More than a quarter did not recommend deception in any study vignette. Written comments of some respondents indicated

that they would try to secure coverage and overturn previous service denials by discussing the vignette patient's situation with the third-party payer, despite the study vignettes' instructions otherwise. Although these physicians may be successful in their appeals, their acceptance of restrictions on medically indicated treatment has significant implications for patient care. Furthermore, current case law holds that physicians who are willing to accept an MCO's limits on provision of care have no immunity from civil liability related to the withholding of care.[30] Respondents who feel strongly compelled to follow contractual rules might be surprised to find that compliance with MCO rules does not decrease their exposure to malpractice or legal obligation to patients.[31] In contrast, the smaller group of physicians who sanction deception in all medically indicated vignettes (cosmetic rhinoplasty excluded) support the equally troubling conclusion that some physicians view deception as an acceptable method of dealing with third-party payer limitations. Acceptance and deception, rather than advocacy, set dangerous precedents for future practice for both the physician involved and the profession.

Despite the nature of our findings, deception is not new to medical practice. Physicians have been known to advocate deception in several situations: lying when they believe it will benefit a patient,[32] choosing not to inform terminally ill patients of their true diagnosis,[33] and intentionally miscoding to protect patient confidentiality[17] or to secure reimbursement for treatment.[6] In more spurious cases, physicians have also used deception for personal benefit, as a means of disguising malpractice, for career advancement, or to defraud payers.[34-36] Hospitals have also been implicated for deceptive practices in dealing with

third-party payers, from subtle "diagnosis related group creep"[37] to more extreme cases of Medicare fraud.[38] However, until recently, deception was unrelated to access to care. Physicians were historically able to treat uninsured patients and those with limited access to care by distributing treatment costs across the remainder of their paying practice.[39] As cost shifting and other methods of providing unreimbursed care have disappeared under managed care, so have the avenues by which physicians can treat patients who lack coverage for specific services.

Our study has some limitations. Although physicians indicated a significant willingness to sanction deception, we are unsure of the extent to which such willingness translates into the actual use of deception in practice. Are physicians as willing to deceive in practice when faced with the possibility of civil or criminal sanctions? Conversely, does the frequent process of attempting to secure patient care and repeated frustration further embolden a physician? What are the implications of recent legislative and judicial attempts to address this issue? Although we cannot be certain, we believe our data indicate that physicians, at a minimum, accept and are willing to use deception as a means of responding to third-party payer restrictions. In addition, our relatively low response rate limited our availability to evaluate effects such as practice in a staff model HMO, patient payer mix, and physician demographics.

In conclusion, the practice of medicine now extends beyond the patient-physician relationship. Physicians and patients are contractually bound to third-party payers and their rules. On occasion, such obligations conflict with physicians' obligations to act as patient advocates. Although using deception to solve these impasses may

succeed in the interim, their long-term costs in loss of integrity and increased practice oversight are high. Situations that produce deception can ultimately only be solved by direct confrontation and frank dialogue between physicians, patients, and payers. Alternatives to deception include broadening existing appeals processes on behalf of individual patients and political advocacy for health care reform. Refusal to initiate a social dialogue regarding the appropriate balance between medical and economic considerations places medicine at risk of becoming a practice of equal parts patient care and subterfuge.

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Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems

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To assess physicians' attitudes toward the use of deception in medicine, we sent a questionnaire to 407 practicing physicians. The questionnaire asked for response to difficult ethical problems potentially resolvable by deception and asked general questions about attitudes and practices. Two hundred eleven (52%) of the physicians responded. The majority indicated a willingness to misrepresent a screening test as a diagnostic test to secure an insurance payment and to allow the wife of a patient with gonorrhea to be misled about her husband's diagnosis if that were believed necessary to ensure her treatment and preserve a marriage. One third indicated they would offer incomplete or misleading information to a patient's family if a mistake led to a patient's death. Very few physicians would deceive a mother to avoid revealing an adolescent daughter's pregnancy. When forced to make difficult ethical choices, most physicians indicated some willingness to engage in forms of deception. They appear to justify their decision in terms of the consequences and to place a higher value on their patients' welfare and keeping patients' confidences than truth telling for its own sake.

(*JAMA*. 1989;261:2980-2985)

PHYSICIANS face many ethical problems in medical practice in which truth telling may appear problematic.[1] In deciding what information to convey to patients, families, and third parties, conflicts often arise between competing values, and one must be chosen over the other. Sometimes physicians judge the use of deception to be the most therapeutic and morally justifiable alternative. Although ethical issues related to truth telling have been well discussed,[2-5] there are no generally accepted guidelines to help physicians in making these difficult decisions. The American Medical Association's "Principles of Medical Ethics" enjoins physicians to "deal honestly with patients and colleagues" without offering specifications.[6] The recent *American College of Physicians Ethics Manual* advises

physicians to act "with sensitivity and without duplicity" when forced to serve conflicting interests,[7] but it does not discuss deception as a separate issue or emphasize truth telling as an overriding moral imperative.

What are physicians' attitudes toward the use of deception to resolve ethical problems in medical practice? How do they reason when considering how much to tell or whether to tell the truth in various situations? These are important questions since physicians' decisions to use deception have implications for patient trust and the quality of their physician-patient relationships. The aggregate of their decisions has implications for public regard of the medical profession. There is only limited information regarding these questions. Physicians' attitudes toward disclosure have been studied in surveys regarding telling cancer patients their diagnoses[8,9] and regarding informed consent.[10-12] To our knowledge, no previous study has addressed deception as a separate issue. To assess physicians' attitudes and stated practices regarding the use of deception, we sent a mail survey to practicing physicians, which explored the following questions: Would physicians say they would choose to use deception under certain circumstances? If so, how would they justify its use? Do physicians' approaches to deception vary according to such factors as age, sex, and specialty?

METHODS

A questionnaire presented four ethical problems in patient care that could potentially be resolved by the use of deception. Case descriptions were followed by multiple-choice options for resolving the problems and a list of possible justifications for the option chosen. Finally, general questions were asked about principles and attitudes toward deception. In the first phase of the study, we sent the questionnaire to 78 residents in internal medicine at a major medical center. Sixty-three (81%) of the residents responded. Analysis of these results led to minor revisions of the questionnaire. We then sent the questionnaire to a sample of 407 practicing physicians randomly selected from a health department's list of 2350 licensed physicians in a state in the Northeast. The sample consisted of 98 general practitioners, 105 surgeons, 106 obstetrician-gynecologists, and 98 internists. Two mailings and one follow-up telephone reminder led to 211 returned questionnaires, a 52% response.

Response distribution of each action and respondents' first justification was computed. Age, specialty, self-rated use of deception, and attitudes toward the use of deception were compared with case-management choices and justifications, using the x^2 statistic. Eleven questionnaires were omitted from statistical analysis because of unanswered or improperly answered questions, although these surveys were reviewed for their written comments.

The mean age of respondents was 49 years, with the following distribution by age categories: ages 20 to 29 years, 6%; 30 to 39 years, 25%; 40 to 49 years, 19%; 50 to 59 years, 22%; and 60 years and older, 28%. The internists were somewhat younger as a group, with a mean age of 43

years, while the mean ages of the obstetrician-gynecologists, general practitioners, and surgeons were between 50 and 51 years. The respondents were 25% internists, 25% obstetrician-gynecologists, 26% general surgeons, 21% general practitioners, and 5% others (these and other figures may exceed 100% because of rounding).

RESULTS

Case vignettes and questions are presented as they appeared in the questionnaire. Physician choices of action and first justifications for action are depicted in Figs 1 through 4. Justifications chosen by fewer than 5% of respondents were consigned to the other or unspecified category.

Case 1

You are seeing Mrs Lewis, a 52-year-old patient of yours, for her annual physical, which reveals no abnormalities. You tell her that everything looks normal and that you are going to order routine blood tests and her annual screening mammography, which you feel is important for women of her age. She is against the mammography, saying that the last time you ordered it, she had to pay for it herself. You know she is of modest means and cannot easily afford it. You are surprised that her health insurance did not cover it. Upon asking your secretary, you learn that the insurance covers the cost of mammography only if there is a breast mass or objective clinical evidence of the possibility of cancer. The secretary tells you that the way to get around this is to put down "rule out cancer" instead of "screening mammography" on the form.

1. How would you fill out the form?

   a. Rule out cancer

   b. Screening mammography

2. If you chose (*a*) to question #1 was it because (choose one, or rank your choices):

   a. You think the insurance company's distinctions are unreasonable.

   b. You feel a stronger obligation to your patient than to the insurance company.

   c. You feel everyone else does it.

   d. You feel the financial hardship on Mrs Lewis would be greater than on the insurance company

   e. Other (please explain).

3. Again, if you chose (*a*) to question #1, do you feel you deceived the insurance company? (Y/N)

4. If you chose (*b*) to question #1, was it because (choose one, or rank your choices):

   a. You think the insurance company's distinctions are reasonable.

   b. It is wrong to deceive a 3rd party for a patient's benefit.

   c. You are worried about the legal/professional liability involved.

   d. You feel such practices are responsible for increased health care costs.

e. Other (please explain).

Choices of action and justification are depicted in Fig 1. Choices 2 *c* and 4 *c* above were not chosen and are thus not depicted. In addition, in response to question 3, 112 (85%) of 132 physicians said they did not believe they deceived the insurance company by choosing "rule out cancer."

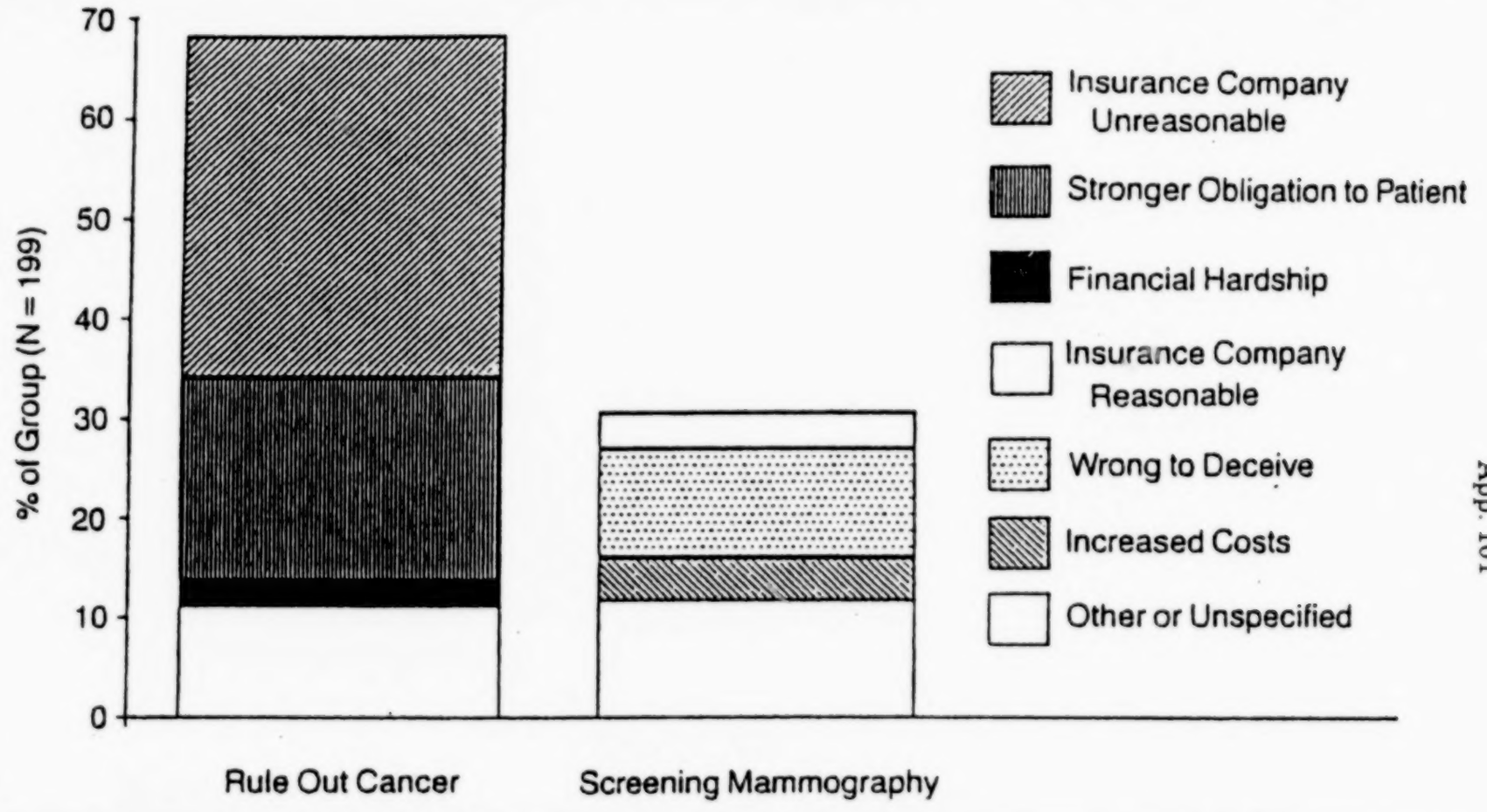

Fig 1.—Case 1. Filling out insurance form.

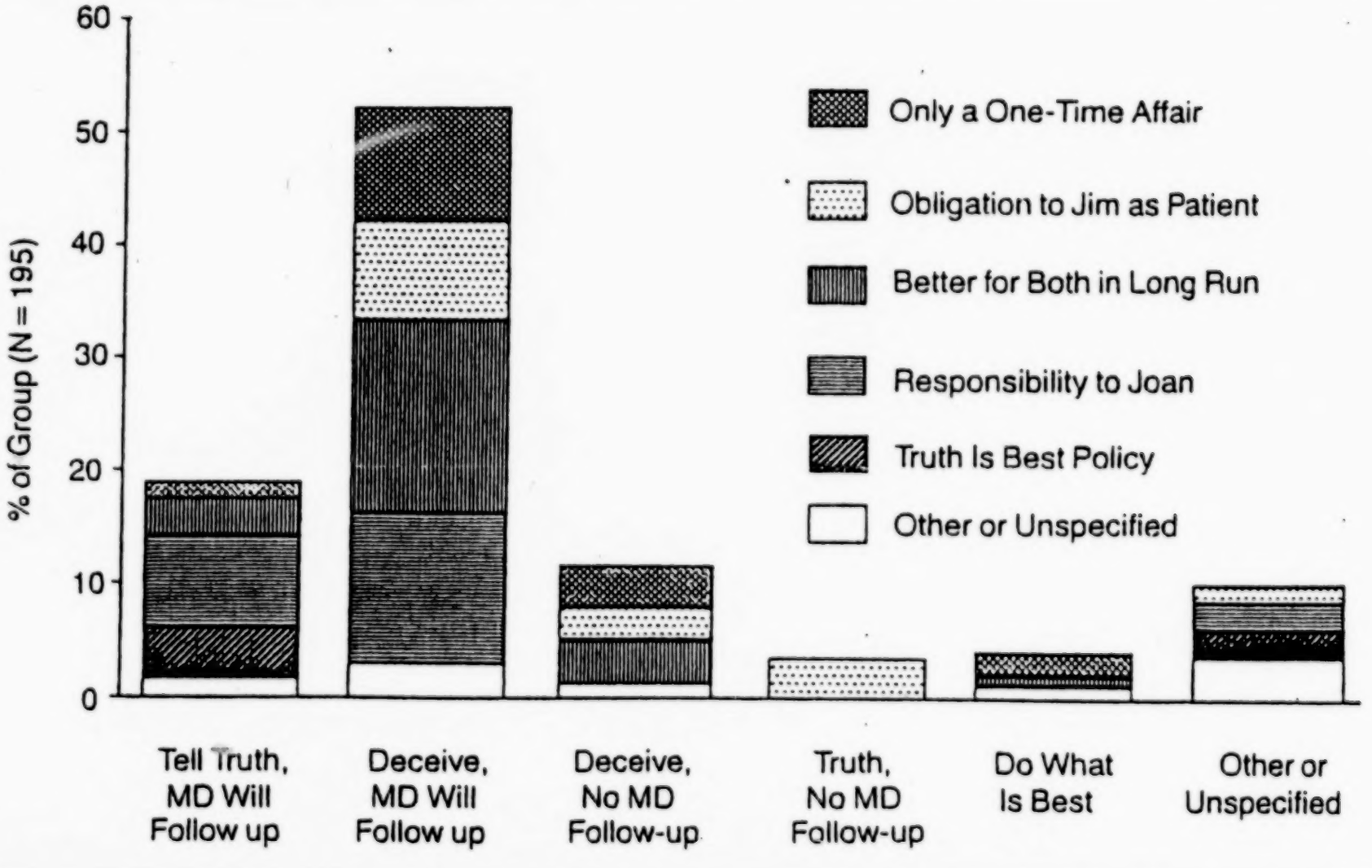

Fig 2.—Case 2. Tell wife about gonorrhea.

Case 2

Jim Wentworth is a 43-year-old married businessman who has been your patient for many years. You are surprised that he comes to see you with complaints of dysuria and purulent urethral discharge. Microscopic exam of the discharge reveals gonorrhea. You tell Jim that the test confirms that he has gonorrhea, and you administer penicillin. You explain that state law requires you to report cases of gonorrhea to the Health Department and that his wife, who is not your patient, must be treated since she has been exposed.

Jim begs you not to report his disease, "I know exactly where I got this," he explains, "I picked up a prostitute a couple of weeks ago when I was at a convention. If you tell Joan, she'll walk out on me. And if you report me to the Health Department, they might call Joan. I swear, I've never done anything like this before. Please don't ruin my marriage by telling Joan!"

After a lengthy conversation, Jim remains adamant about not telling Joan, and you are convinced the marriage would be in jeopardy if she found out.

5. Would you (choose one):

a. Insist that Jim tell Joan he has gonorrhea and bring her in for treatment. If this is not done within 48 hours, you will contact her and tell her yourself.

b. Agree to have Jim tell his wife that it is a nonspecific urethritis, but insist she be treated. If this is not done within 48 hours, you will contact her and tell her to get treated.

c. Agree to have Jim tell his wife that it is a nonspecific urethritis and give him enough tetracycline to treat his wife.

d. Tell Jim he must tell Joan he has gonorrhea, but do not follow up yourself.

e. Tell Jim to tell Joan what he thinks best.

f. Other (please explain).

6. In choosing your answer, what was/were your prime considerations? (choose one, or rank order):

a. You don't believe a one-time affair warrants the break up of a marriage.

b. Since Jim is your patient, your obligation is to treat him and respect his privacy in deciding how Joan will be treated.

c. You feel the majority of your colleagues would do the same.

d. You feel it would be better in the long run for both Jim and Joan.

e. You feel you have a responsibility to Joan as well.

f. You feel truthfulness is the best policy.

g. You feel you have an obligation to society.

h. Other (please explain).

Choices of action and justifications are depicted in Fig 2. Physicians were also asked if they would report this case to the health department. Seventy-eight percent indicated that they would. We further asked why they chose to do so. Twenty-five percent chose the option, "your legal

obligation outweighs the risk of Joan being informed," 30% chose "your obligation to society outweighs the risk Joan might be informed," and 34% chose "you would ask the Health Department not to call Joan."

Case 3

Sherry Jacobs, a 15-year-old young woman, comes to your office complaining of nausea and vomiting. Her mother is along. You know them well, as you have been treating the family for 10 years. When the mother leaves, you learn Sherry has been sexually active for the past year. A pregnancy is positively confirmed and estimated at about 10 weeks.

Sherry immediately speaks of abortion, and says she plans to go to a neighboring state where this can be done without her parent's knowledge. (State law prohibits abortions for minors without a parent's consent.) She begs you not to tell her parents. You know they would attempt to prevent the abortion if they knew and much family tension would result. Yet, if the parents found out later it might destroy the relationship you have built with them. You urge Sherry to share the news with her parents and discuss options with them. She remains adamant.

9. When Sherry's mom returns and asks your diagnosis, you tell her (choose one):

a. Sherry is pregnant and offer your support and availability as a counselor.

b. I've talked this over with Sherry and she can talk with you about it.

c. Sherry's symptoms are due to something common that's going around.

d. Sherry has a gastroenteritis, which should clear up in a week or so.

e. Other (please explain).

10. In choosing your answer, what was/were your prime considerations? (choose one, or rank order)

a. You were guided by your moral view on abortion.

b. You did not want to violate doctor-patient confidentiality.

c. You believe Sherry's mother has a right to know.

d. You believe Sherry is too young to make this decision on her own.

e. You believe this is best for Sherry.

f. You are concerned about your relationship with the family.

g. Other (please explain).

Choices of action and justifications are depicted in Fig 3.

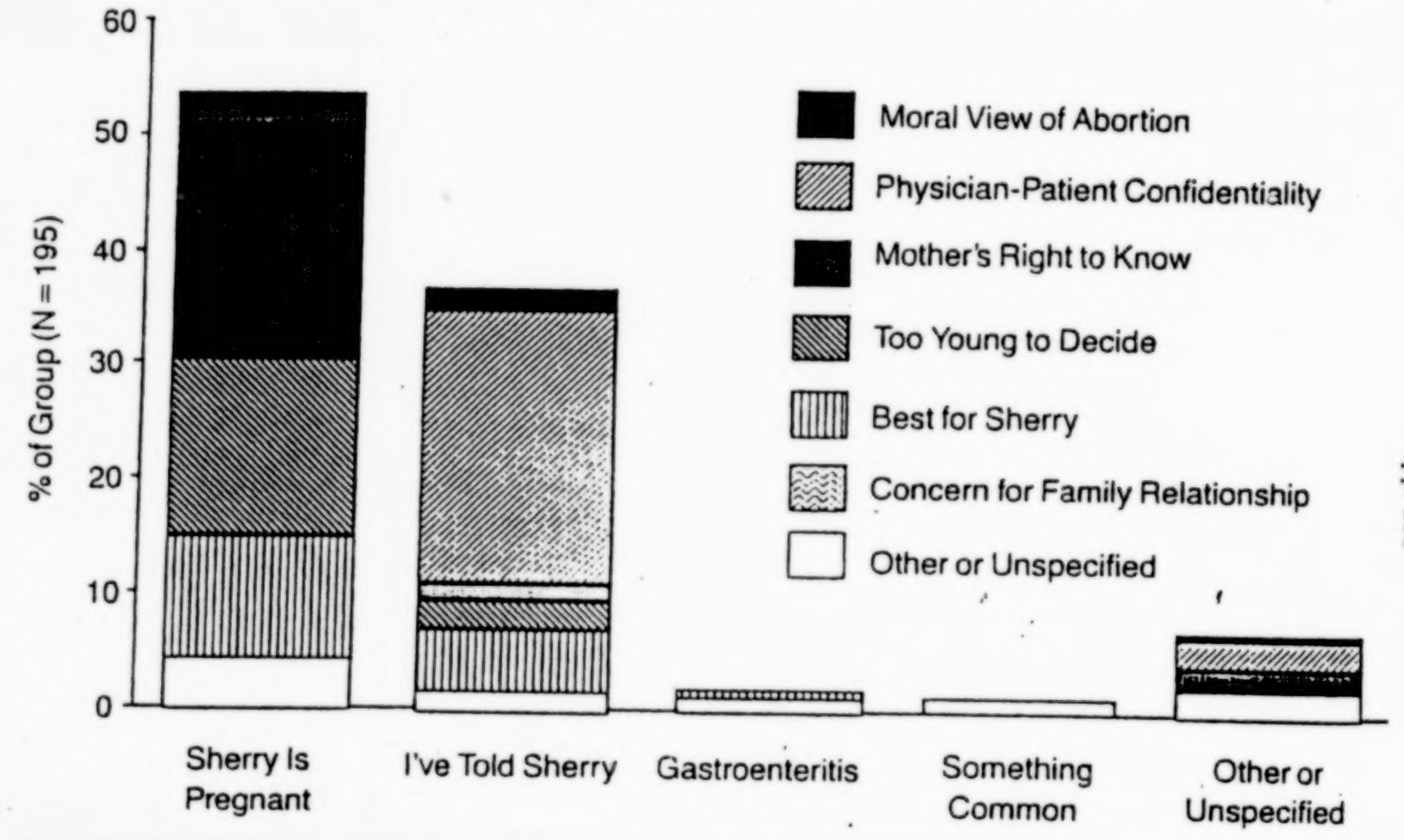

Fig 3.—Case 3. Pregnant teenager.

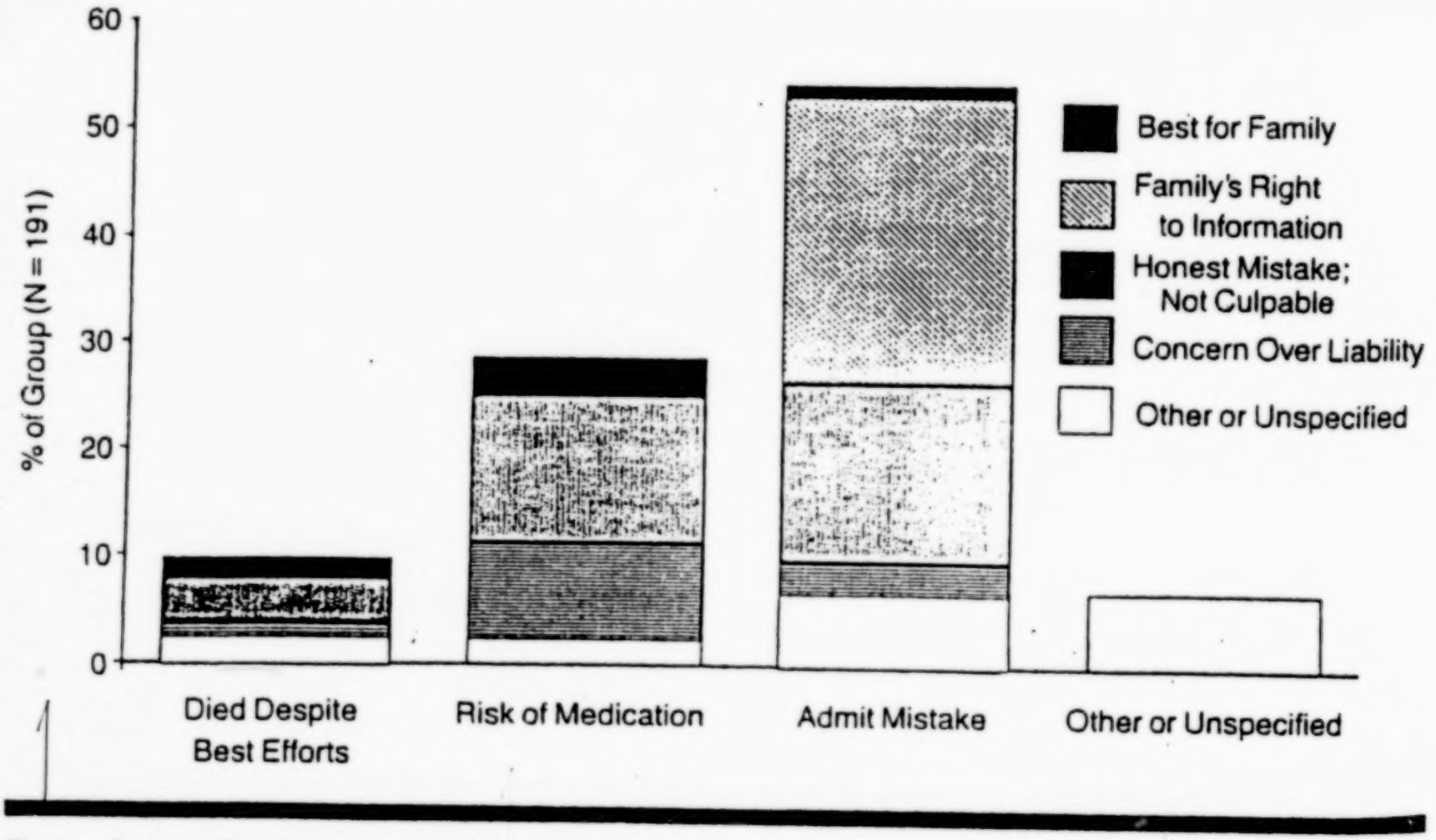

Fig 4.—Case 4. Physician error; patient dies.

Case 4

An 80-year-old man with severe hypertension comes into the hospital with confusion, papilledema, and a blood pressure of 250/150 mm Hg (hypertensive crisis). Having decided to start him on diazoxide, you administer a vial labeled with the usual dose of 100 mg. Shortly thereafter, the patient's blood pressure drops and despite resuscitative efforts, he dies. In reviewing his medications, you find that the vial actually contained 1000 mg of a "100-mg/cc" solution. You are thus sure you accidentally administered a fatal dose.

11. When informing the family about the patient's death, you would (choose one):

a. Emphasize that the patient was very sick but despite your best efforts, he died.

b. Emphasize the patient was very sick and required strong medication. As an unfortunate, but known risk of the medication, his blood pressure dropped too low and he died.

c. Say you inadvertently gave him too much medication over too short a time, which given his serious condition probably caused his death.

d. Other (please explain).

12. In choosing your answer, on what did you base your decision? (choose one, or rank order)

a. What was best for the family.

b. The family's right to full information.

c. Your belief that you made an honest mistake and are not culpable.

d. Your concern about legal/professional liability.

e. Other (please explain).

Choices of action and justifications are depicted in Fig 4.

Among the four cases, choices of deceptive alternatives (1, *a*; 5, *b*; and *c*; 9, *c* and *d*; and 11, *a* and *b*) were statistically independent (by x^2 test); that is, a physician's choice in any one case was not predictive of that physician's choice in any of the other three cases.

Questions Regarding Principles

Physicians were asked in an open-ended manner to describe their basic principles regarding the use of deception to benefit their patients. One hundred nine (54%) of 202 physicians described their principles. Forty-eight (44%) of 109 physicians made explicit statements about the importance of truthfulness. Fourteen (13%) of 109 physicians asserted that physicians should never deceive. However, 95 (87%) of 109 physicians indicated that deception is acceptable on rare occasions, giving a variety of reasons: if the patient would be harmed by knowing the truth, to circumvent "ridiculous rules," and to protect confidentiality. A comment that was typical of this group was: "I try to take everything on a case by case basis and to tailor my actions to the people and the situation I confront. . . . The only basic policy is first do no harm. Honesty is *usually* the best policy."

Forty (37%) of 109 physicians stated their principles in terms of deceiving patients. Of these, the majority stressed the general importance of honesty, but stated that shaping the truth (ie, being overly optimistic or using less threatening terms) is, on occasion, necessary.

Eighteen of those 40 physicians volunteered that nondisclosure is sometimes necessary when full disclosure would harm a patient.

We asked physicians to rank the factors they consider when justifying decisions to use deception for their patients. Their replies are presented in Table 1. Note that 31 of 60 respondents not answering this question stated in response to a later question that they never use deception with patients.

Questions Regarding Attitudes and Practices

We next asked physicians questions that elicited attitudes and estimated the frequency of the use of deception by patients, society at large, other physicians, and themselves. The majority believed that their patients did not expect them to use deception and that they never or rarely use deception with patients. They perceived deception to be more common among their patients, other physicians, and society at large (Table 2).

Table 1.—First and Second Justifications for the Use of Deception

Rank the Top 4 Factors You Consider When Justifying Your Decision to Use Deception for Your Patient	% Choosing Justifications		
	First (n = 140)	Second (n = 116)	Total
The benefits (for the patient) outweigh the potential costs or harm	71	13	84
The value of the patient's privacy and confidentiality	9	35	44
Possible harm to others that may be at risk	2	30	32
Moral convictions regarding deception	14	12	26
Possible legal ramifications	1	7	8
Obligation to society	2	3	5

Table 2.—Responses to Attitude Questions

	% of Respondents (n = 193)			
	Strongly Agree	Agree	Disagree	Strongly Disagree
"My patients expect me to utilize deception for their benefit."	2	25	38	35
"If I were a patient, I would expect my physician to utilize deception on my behalf."	3	23	36	38
	Never	Rarely	Occasionally	Often
"How often do you feel your patients intentionally deceive you?"	2	22	66	11
"How often do you feel deception is used in society at large (ie, by politicians, salesmen, lawyers, in advertising, etc)?"	0	1	13	87
"How often do you feel deception is utilized by physicians?"	1	26	59	15
"How often do you utilize deception with patients?"	25	55	18	1

Effects of Attitudes and Stated Practices on Answers to Cases

There was little relationship between physicians' answers to the case questions and their stated general attitudes toward the use of deception. Those who said they "never" use deception, when compared with those choosing "rarely," "occasionally," or "often," were less likely ($P<.02$) to choose deceptive answers in cases 1 and 2. In case 4, this difference approached statistical significance ($P=.05$). Still, of the 49 physicians who asserted that they "never" deceive, 26 (53%) chose "rule out cancer" in case 1, twenty-four (49%) chose to allow Jim to mislead Joan about his diagnosis in case 2, and 16 (33%) chose to misinform the family about their mistake in case 4.

Effects of Sex, Age, and Specialty on Choices

There were too few women in our sample to determine differences in responses by gender. There were two differences by age category. In case 2, there was a stepwise increase by age category in the percentage of physicians who would inform Sherry's mother about the pregnancy: ages 20 to 29 years, 2 (18%) of 11; ages 30 to 39 years, 20 (42%) of 48; ages 40 to 49 years, 20 (54%) of 37; ages 50 to 59 years, 24 (60%) of 40; and ages 60 years or older, 37 (70%) of 53. In case 4, physicians over 50 years of age were less likely to tell the family of their mistake (45/92 [49%] would tell) than those under 50 years of age (60/90 [67%] would tell) ($P<.03$, Yates' Corrected x^2).

There was one notable specialty difference: obstetrician-gynecologists were clearly different from other physician categories in case 3. Twenty-seven (63%) of 43 physicians would withhold information about Sherry's

pregnancy from her mother, while 54 (39%) of 140 physicians of other groups would do so ($P<.002$). Obstetrician-gynecologists were more than twice as likely than others (20/44 [46%] vs 30/135 [22%]) to cite respect for confidentiality as their justification ($P<.05$).

COMMENT

Does deception have a place in ethical medical practice? If deception is sometimes warranted, how do physicians reason when considering its use? If physicians' attitudes toward the first question do not match patient expectations, patient trust in individual physicians and in the profession as a whole may be diminished. Because decisions to deceive are often difficult, the answer to the second question could shed light on physicians' core values concerning medical practice. This preliminary survey suggests that the majority of our physician-respondents are willing to use deception in at least some situations when confronted by conflicting moral values. They evaluate the consequences of their decisions and appear to place a higher value on their patients' welfare and keeping patients' confidences than on truth telling for its own sake.

Physician's decisions regarding deceptive behaviors must be based on their understanding of what constitutes deception. To deceive is to make another believe what is not true, to mislead.[13] However, physicians' comments on our survey suggests that they have different personal definitions of deception. Some believe that they never or rarely deceive: one physician wrote, "No good doctor 'deceives'! Perhaps better terms might be: consideration, expression, compassion, . . . support, tailor management to patients' needs." Others believe that they frequently

deceive: "Deception . . . every time we say 'you'll feel a pinch' for a lidocaine injection or 'this won't hurt' for a bone marrow. . . . In an effort to be kindly and helpful and positive we *frequently* deceive our patients as to our true thoughts at various times." Others may at times confuse the truth with truthfulness, perhaps not recognizing that true statements can sometimes mislead. For example, some who chose "rule out cancer" in case 1 wrote, "I *am* ruling out cancer," a true statement that is nevertheless deceptive to the insurance company.

There are many forms of deception. One can actively deceive by lying, equivocating, and using vague speech. One can passively deceive by nondisclosure, by allowing another to deceive, or by failing to correct a misconception. Physicians may have differing attitudes about the relative acceptability of the different forms of deception. As in euthanasia, the passive forms of deception may be regarded as less wrong than the active forms. It could be, for example, that in case 2, physicians more readily chose to participate in the deception of Jim's wife because it was Jim who was doing the initial deceiving. We did not specifically investigate comparative attitudes toward different forms of deception. This would be an important area for further study.

In physician-patient encounters, it may be useful to further discuss decisions to deceive in terms of two distinct issues: who is being deceived and who will benefit from the deception. For example, physicians may deceive patients, patients' families, insurance carriers, and themselves. One or more of these parties may benefit from the deception. Thus, many combinations are seen. A physician may deceive a patient with cancer to avoid psychological distress in the patient and family members. An insurance

carrier may be deceived to secure payment for a needed test, benefiting the patient and the physician. Physicians may benefit from self-deception, as in believing that it is too uncomfortable for dying patients to discuss end-of-life issues, when it is really too uncomfortable for themselves.

There has been some previous work regarding physicians who deceive patients about their diagnoses. One of us (D.H.N) and colleagues,[8] studying physicians' attitudes toward "telling" the cancer patient, found that 98% of respondents reported a general policy of disclosure. Physicians reported making exceptions to that policy on rare occasions, based on considerations of age, intelligence, emotional stability, and a relative's wish about telling the patient. Although lying to patients may be abjured, the use of vague speech and non-disclosure of information may be somewhat more common in practice.[14,15] In one study, 20% of neurologists favored withholding anxiety-provoking information from adult patients with seizure disorders and their families.[10] In another, vague information about diagnosis and treatment was given to 39% of 1262 women with newly diagnosed breast cancer.[16] Case law from various states provides that physicians have discretion in determining which hazards of contemplated procedures should be revealed to patients.[17] Disclosure practices merit further study and reassessment in light of findings that patients report a preference for far more detailed disclosure than physicians routinely offer.[10] There are few documented harmful effects of disclosure[9] and many proved benefits.[9,18]

Our data suggest that deceiving a third party to benefit patients may be quite acceptable to physicians in some situations and less so in others. Most of our respondents were willing to misrepresent a screening test as a

diagnostic test to ensure payment. This raises the possibility that offering "creative diagnoses" to thirty-party payers may be a widespread practice. In case 2, the majority of physicians were willing to participate in a deception of Jim's wife. However, in case 3, few were willing to lie to Sherry's mother. The factors that may contribute to these different attitudes, such as differences in the magnitude and forms of the required deception, the proximity of the parties deceived, and differing justifications for deception should be the subject of further investigation.

This study suggests that physicians may commonly engage in self-deception, which may facilitate other forms of deception. In case 1, the majority of both groups who chose "rule out cancer" said that they were not deceiving the insurance company, even though the case example was designed to make it clear that they were. Even the 25% of physicians who said they "never" use deception often chose deceptive answers to our case examples. One example is a physician who wrote many comments affirming the physician's duty to tell the truth. He stated that he "never" used deception with patients and indeed chose "screening mammography," "insist that Jim tell Joan he has gonorrhea . . . , and "Sherry is pregnant." However, in case 4 he chose, "emphasize that the patient was very sick but despite your best efforts, he died." He explained, "Narrowly phrased, this *is* the *truth* isn't it – the 'best efforts' of your practice were *your best* – stupid – but 'the best' for you!"

Our survey suggests that under extreme circumstances, some physicians would consider deceiving to benefit themselves. In case 4, more than a third of physicians said they would provide incomplete or misleading information to a family about a mistake that led to a

patient's death. While many argued in their comments that the family would only be further hurt by the knowledge of the mistake, deception clearly offered benefits to the physicians as well. While some case law suggests a legal duty to disclose mistakes to patients or their families, there is no uniform legal code that demands such disclosure.[17,19] The codes of medical ethics do not discuss this issue.[6,7]

In making their decisions to deceive, the majority generally appeared to adopt a consequentialist approach. That is, they appealed to the good consequences produced and the bad consequences avoided by deception. This finding is consistent with a review of ethical positions adopted by writers on ethical issues of cancer.[20] The great majority of physician-respondents indicated an overriding concern for their patient's welfare and indicated that they would deceive if necessary to protect that welfare. This was evidenced by the two most commonly stated justifications for deception: the benefits outweigh the costs and the protection of a patient's confidences. Only after these patient-centered justifications were others mentioned: concern for possible harm to specific others who may be at risk, and, much less frequently, moral convictions about deception, concern for legal ramifications, and obligation to society.

It is clear from their written comments that our respondents are dedicated and thoughtful physicians who make difficult decisions at difficult times. Overall, they indicated a respect for truth telling. In a society where they perceived deception to be quite common, they believed that they used deception far less than the norm. They seemed to agree with Brody's[21] conclusions about truth telling: "We cannot agree with criteria that elevate

the truth as a fundamental moral value for its own sake, independent of the effect that the truth will have on the individual. . . . The fundamental value at issue is that of respect for persons. Truth is valuable because in the vast majority of cases, respect for truth is a way of demonstrating respect for persons; but in rare instances respect for persons might demand that the truth be given a lower priority compared to other considerations."

Still, this study raises a number of questions about physicians' attitudes and practices. Are the attitudes revealed by this survey consistent with physicians' and patients' ideals for ethical medical practice? The physicians' overriding concern with patient welfare, consistent with Hippocratic tradition, gives less consideration to questions about the potential harm to others of deceiving. What if Joan, thinking nonspecific urethritis is a minor infection, stops taking the tetracycline and gets pelvic inflammatory disease? What about the others in the insurance pool whose physicians won't write "rule out cancer"? What harm may deception do to the physician's self-image and to the patient's trust? What harm may ensue if the policy of deceiving in certain circumstances becomes more general, and how will that affect public trust in the profession? Although patient advocacy is a cherished medical tradition, its role in decision making may need to be reassessed and weighted against other considerations.

These data have implications for policy, teaching, and future research. In case 1, our respondents seemed to be saying that health insurance carriers should restructure their policies toward covering more preventive health care. Failure to do so may be perpetuating a system that gives an advantage to those patients whose physicians disregard

guidelines in filling out forms. For teachers of medical ethics, these data may stimulate discussions about priorities among conflicting moral imperatives. It would be useful to have more discussions about physician deception to others to benefit patients or to prevent recognition of a mistake. A recent presentation of basic curricular goals in medical ethics does not mention these issues.[22] The study questionnaire and others like it may be useful as teaching tools. Specific cases are effective in illustrating abstract ethical principles, and the specific and general questions force students to make choices that can stimulate them to examine their values.

This study must be considered exploratory. Its response rate and limited scope preclude generalizations about the prevalence and nature of physician deception. Further empirical research is clearly indicated, focusing not only on physicians but also on patients and other professional groups. Do other professional groups have similar standards regarding the use of deception? What do patients think their physicians' behavior should be? What are the nuances of physician reasoning in justifying deception? How do they think about the ethical issues of patient autonomy, beneficence, and justice? To what extent and how do they weigh benefits and risks? How do attitudes toward patient care affect choices (eg, are physicians with more paternalistic attitudes more likely to consider some forms of deception acceptable)? It would be useful to interview physicians to more fully understand the subtleties of their decision making. In addition, some actual practices, such as furnishing "creative diagnosis" to insurance carriers, could be determined.

While further empirical research may help clarify the ethics of deception, normative questions will remain. Is it

ever ethical to deceive? If some deception is ethically acceptable, where should the lines be drawn? How could codes of medical ethics more explicitly address the physician's obligation to be truthful and more clearly define which moral imperatives take precedence in situations of conflict? A better understanding of deception should lead physicians to a clearer articulation of the principles that guide their actions. In the final analysis, questions about physicians' relationship to truthfulness will only be resolved by enlightened debate and, ultimately, by each physician guided by his or her conscience.

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The questionnaire used in this survey is available from the first author.

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Aug 13 2001

PRIVACY

Guarding medical secrets, at a cost

[Picture Omitted In Printing]

Doctors are withholding medical information from health records, and even lying, to help patients protect their privacy. In a new survey of 344 members of the Association of American Physicians and Surgeons, 87 percent reported that patients had asked them to exclude data from their records, and 78 percent had complied. Nearly one fifth admitted to making false entries.

Mark Schiller, a San Francisco Bay area psychiatrist and member of the AAPS board of directors, says that because of privacy concerns, he only takes basic notes about patients' condition and medications. Yet an incomplete or distorted record poses its own risks. He says he unnecessarily prescribed anti-psychotic medications to patients who had not divulged their cocaine or crystal meth habits. "I now have to balance privacy concerns with the need to communicate with other physicians," says Schiller.

– *Dana Hawkins*

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Physicians dedicated to the health of America

Fundamental Elements of the Patient-Physician Relationship

From ancient times, physicians have recognized that the health and well-being of patients depend upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocates and by fostering these rights:

1. The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

2. The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

4. The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

5. The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as furthef treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

6. The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate.

(Source: Report of the Council on Ethical and Judicial Affairs of the American Medical Association. Originally adopted June 1990. Updated 1994.)

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JAN

Accommodating Individuals with Back Impairments

Job Accommodation Network
1-800-526-7234 (V/TTY)
http://www.jan.wvu.edu
A service of the Office of Disability Employment Policy
of the U.S. Department of Labor

By John Greer, MS

Preface

It is estimated seventy-five percent of the population will have low back pain at least once. While most individuals with back pain will recover without invasive treatment, some will have to deal with limitations for the rest of their lives. Accommodations for individuals with back impairments help individuals overcome these limitations and help keep them working.

In 1999, the Bureau of Labor Statistics estimated nearly half of on-the-job injuries involving time away from work were caused by back injuries. Of these, 19.1% of the workers were out for 31 days or more. Employers involved in proactive workers' compensation case management focus on early return-to-work; with the use of accommodations, a win-win situation for employer and employee can result. Employers may also have to consider accommodations for employees injured off the job under the Americans with Disabilities Act (ADA). Employer responsibilities vary under the ADA but often effective accommodations enable employees with back impairments to perform job functions.

When considering accommodations for people with back impairments, the accommodation process must be conducted on a case-by-case basis. Functional limitations vary from person to person and job to job. When determining effective accommodations, the person's individual abilities and limitations should be considered and problematic job tasks must be identified. Therefore, the person with the back impairment should be involved in the accommodation process. If further information on the responsibilities of an employer and the rights of the individual under the ADA are needed, please feel free to contact JAN.

Not all people with back impairments will need accommodations to perform their jobs and many others may need only a few accommodations. For those who need accommodation, the following pages provide basic information about common limitations, symptoms, useful questions to consider, and accommodation possibilities. The following is only a sample of possibilities to consider; numerous other solutions and considerations may exist.

In addition to accommodation ideas, the following material includes information regarding some of the products available to accommodate people with back impairments. The information represents a sample of the possible products and vendors available. Numerous other products and vendors may exist. Also included in this publication is a list of resources for additional information.

What is back pain?
The spinal column is broken down into five sections: cervical (neck), thoracic, lumbar, sacrum, and coccyx. Ligaments, tendons, and muscles connect to vertebrae to provide structural support for the body. Between the

vertebrae are shock absorbing cushions called discs. Pain can occur when a ligament, tendon, or muscle becomes sprained or strained. Pain can also occur when one or more discs bulge out of designated spaces and put pressure on nerves.

What are the symptoms of back pain?
Symptoms of back pain can be localized or widespread radiating from a central point in the back. Sciatica is pain starting in the lower back and traveling down one or both legs.

What causes back pain?
Back pain may be caused from overuse, acute injury, vertebrae degeneration, nerve impingement, spinal stenosis (narrowing of the spinal canal), infection, and tumors.

Who gets back pain?
It is estimated that 75% of the population will have at least one episode of back pain during a lifespan. Contributing factors to back pain may include poor conditioning, overuse, obesity, cigarette smoking, and age.

How is back pain treated?
Most back injuries are treated with non-invasive treatment techniques. Treatment options include drug therapy, chiropractic adjustments, acupuncture, physical therapy, and rest. In a few cases surgery may need to be performed; some surgery options are vertebrea fusion, discectomy, and laminectomy.

QUESTIONS TO CONSIDER WHEN DETERMINING ACCOMMODATIONS

1. What symptoms or limitations is the individual with back pain experiencing?

2. How do these symptoms or limitations affect the person and the person's job performance?

3. What specific job tasks are problematic as a result of these symptoms and limitations?

4. What accommodations are available to reduce or eliminate these problems?

5. Are all possible resources being used to determine possible accommodations?

6. Has the employee with back pain been consulted regarding possible accommodations?

7. Once accommodations are in place, would it be useful to meet with the person with back pain to evaluate the effectiveness of the accommodations and to determine whether additional accommodations are needed?

8. Do supervisory personnel and employees need training regarding back pain, other disability areas, or the Americans with Disabilities Act?

ACCOMMODATION CONSIDERATIONS FOR PEOPLE WITH BACK IMPAIRMENTS

Activities of Daily Living

- Allow use of a personal attendant at work
- Allow use of a service animal at work
- Make sure the facility is accessible

- Move workstation closer to the restroom
- Allow longer breaks
- Refer to appropriate community services

Fatigue and Weakness

- Reduce or eliminate physical exertion and workplace stress
- Schedule periodic rest breaks away from the workstation
- Allow a flexible work schedule and flexible use of leave time
- Allow work from home
- Implement ergonomic workstation design
- Provide a scooter or other mobility aid if walking cannot be reduced

Gross Motor Impairment:

General

- Modify the work-site to make it accessible
- Provide parking close to the work-site
- Provide an accessible entrance
- Install automatic door openers
- Provide an accessible restroom and break room
- Provide an accessible route of travel to other work areas used by the employee
- Modify the workstation to make it accessible

• Make sure materials and equipment are within reach range

• Move workstation close to other work areas and break rooms

Industrial

• Provide overhead structure for lifting devices

• Modify the work area to make it adjustable

• Place frequently used tools and supplies at or near waist height

• Provide low task chairs for work that cannot be brought to waist height

• Provide stand/lean stools and anti-fatigue mats for standing work

• Make wheelchairs, scooters, industrial tricycles, or golf carts available if walking long distances is required

• Provide compact lifting devices to push and pull supplies and tools from storage

Office

• Provide a height adjustable desk and ergonomic chair

• Move workstation close to common use office equipment

• Provide low task chair and rolling safety ladder to access high and low file drawers and supplies

• Provide a cart to move files, mail, and supplies

• Provide a lazy Susan carousel or desktop organizers to access frequently used materials

Service

• Provide anti-fatigue mats and stand/lean stools for functions requiring long periods of standing

• Provide a height adjustable desk and ergonomic chair

• Move workstation close to commonly used office equipment

• Provide compact lifting devices to push and pull stock and supplies from shelves

• Provide carts to move supplies and stock

Medical

• Provide a spring bottomed linen cart

• Make patient lifting and transfer devices available

• Make wheelchairs, scooters, industrial tricycles, or golf carts available if walking long distances is required

• Train employees on proper lifting techniques and on proper use of patient lifting and transfer devices

• Provide powered beds for transporting patients

• Provide a height adjustable desk and ergonomic task chairs to fit use for different people

EXAMPLE ACCOMMODATIONS FOR PEOPLE WITH BACK CONDITIONS

A systems administrator with a back impairment is required to move, lift, and carry computers throughout the office. The person was accommodated with a compact, adjustable height lifting device with straps to secure the load.

A maintenance worker with a bending and lifting restriction due to a back injury is required to lift manhole covers. The worker was accommodated with a truck mounted jib crane and manhole cover lifter.

A clerical worker with scoliosis has sitting and standing restrictions. Because the worker is required to work at a desk a majority of the time, the worker was accommodated with an ergonomic workstation evaluation, ergonomic chair, and a sit/stand computer workstation.

A mechanic with a bending restriction due to a low back impairment has problems accessing the engine compartment and law task areas of vehicles. The mechanic was accommodated with a tire lift, a mechanic's low task chair, and a specialty creeper designed to support the body while accessing engine compartments.

A file clerk with a back impairment has functional limitations limiting her ability to bend and access files in low file drawers. An electric automated filing system was purchased to allow accessing of file drawers at a standing height.

A chemical process plant worker is limited in his ability to turn large wheel valves due to a back injury. The worker was accommodated with a specialty tool designed to increase torque on wheel valve handles.

An appliance delivery driver with a lifting restriction due to a low back injury was accommodated with a stair climbing hand truck. This battery-operated piece of equipment also doubles as a lift gate to help lower appliances on and off the truck.

A grocer check-out person with a standing restriction due to a back injury was accommodated with a sit/lean stool and anti-fatigue mats.

A mailroom worker with a push/pull restriction was required to deliver the mail on a cart that weighed more than the individual's push/pull restriction. An accommodation of a motorized cart allowed the person to stay on the job.

A truck driver with a back impairment was limited in the time he could drive. Accommodations of a suspension seat and a vehicle cushion designed to reduce vibrations allowed the driver to comfortably sit for longer periods of time.

A health care worker with a lifting restriction was accommodated with patient transfer devices and individualized training on proper use and selection of the equipment.

PRODUCTS

There are numerous products that can be used to accommodate people with back impairments. JAN's Searchable Online Accommodation Resource at <http://www.jan.wvu.edu/soar> is designed to let users explore various accommodation options. Many product vendor lists are accessible through this system; however, JAN provides these lists and many more that are not available on the Web site upon request. Contact JAN directly if you have specific

accommodation situations, are looking for products, need vendor information, or are seeking a referral.

Sample products include:

Adjustable / Ergonomic Chairs
Compact Lifting Devices
Ergonomic Equipment
Independent Living Aids
Patient Lifting Devices
Sit / Stand Workstations
Stand / Lean Stools
Stair Climbing Hand Trucks
Supine Workstations

Gaming the System

Dodging the Rules, Ruling the Dodgers

E. Haavi Morreim, PhD

•Although traditional obligations of fidelity require physicians to deliver quality care to their patients, including to utilize costly technologies, physicians are steadily losing their accustomed control over the necessary resources. The "economic agents" who own the medical and monetary resources of care now impose a wide array of rules and restrictions in order to contain their costs of operation. However, physicians can still control resources indirectly through "gaming the system," employing tactics such as "fudging" that exploit resource rules' ambiguity and flexibility to bypass the rules while ostensibly honoring them. Physicians may be especially inclined to game the system where resource rules seriously underserve patients' needs, where economic agents seem to be "gaming the patient," with needless obstacles to care, or where others, such as hospitals or even physicians themselves, may be denied needed reimbursements. Though tempting, gaming is morally and medically hazardous. It can harm patients and society, offend honesty, and violate basic principles of contractual and distributive justice. It is also, in fact, usually unnecessary in securing needed resources for patients. More fundamentally, we must reconsider what physicians owe their patients. They owe what is theirs to give: their competence, care and loyalty. In light of medicine's changing economics, two new duties emerge: economic advising, whereby physicians explicitly discuss the economic as well as medical aspects of each treatment option; and economic advocacy, whereby physicians intercede actively on their patients' behalf with the economic agents who control the resources.

(*Arch Intern Med.* 1991; 151; 443-447)

Pauline Stafford had lung cancer. Before surgery, Mrs. Stafford was referred for computed tomography to determine whether the cancer had yet metastasized to her brain. Her insurance did not cover screening procedures, however, and would reject the claim if "rule out brain tumor" were written the space marked "diagnosis." And so the physician directed his office staff to write "brain tumor," even though the test showed she had no tumor. When Pauline subsequently received in the mail a statement of her insurance benefits she saw the entry under "diagnosis" and concluded the worst. Two days later, after preparing her husband's dinner and typing out his daily business agenda, Stafford hanged herself. On the appeal of a $200,000 verdict against the physician and Neurological medicine, Inc, the US Court of Appeals upheld the jury's finding that the erroneous entry on the claim form was the proximate cause of Stafford's suicide and ruled that their financial award to her husband was not excessive.[1]

The case of Pauline Stafford is not only a sad story. It captures one of the most vexing dilemmas of medicine's changing economics: physicians are expected to deliver quality care to their patients, including sometimes to utilize costly technologies, yet they are steadily losing their accustomed control over the necessary medical and monetary resources. No longer will insurers cheerfully pay out large sums, simply on a physician's say-so. However, physicians can still exert considerable indirect influence over resources by "gaming the system," using tactics such as "fudging" that enable one to skirt resource rules while appearing to comply with them. In this paper we will see

how this awkward situation has come about, why "gaming" can be tempting, why it is hazardous, and most importantly, how this predicament forces us fundamentally to reevaluate physicians' obligations to their patients.

PHYSICIANS' OBLIGATIONS, OTHERS' RESOURCES

We can be brief in exploring the origins of the problem, for that groundwork has been laid elsewhere.[2-4] It begins with physicians' obligations of fidelity to their patients. Traditionally, fidelity is necessary because patients are vulnerable. They may have physical, emotional and intellectual infirmities; their usually minimal medical knowledge requires them to trust in the physician's expertise; and treatment often requires them to expose personal intimacies and sometimes to incur substantial risk. Physicians therefore are obligated to be medically competent and to promote the patient's interests, even above their own.[5]

Over the years, medical competence has come to include not only the duty to keep abreast of new information, but to use appropriate technologies, such as x-rays and biopsies.

If physicians, as an aid to diagnosis, ie, judgment, do not avail themselves of the available scientific means and facilities for the collection of the *best* factual data upon which to arrive at the diagnosis, the rest is not an error of judgment but negligence in failing to secure an adequate factual basis on which to support that diagnosis or judgment.[6 (p. 173), 7-9]

Furthermore, in requiring the physician simply to "take the x-rays, or have them taken,"[10] and to keep patients in the hospital as long as is medically necessary (regardless of insurers' reimbursement decisions,"[11] courts have shown little or no interest in who owns the x-ray equipment or hospital bed, or who must pay the staff who tend them. "Whether the patient be a pauper or a millionaire, whether he be treated gratuitously or for reward, the physician owes him precisely the same measure of duty, and the same degree of skill and care.[12 (p. 677)] White it is unclear just how far physicans' legal duties to use technologies actually reach (eg, the physican is not required to purchase the patient's prescription medications out of his or her own pocket), the physician is usually well-advised to use whatever technological resources are clearly part of the standard of care.[4]

Morally, it has similarly been routine to believe that physicians in the clinical setting "are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations."[13 (p. 1573)] The physician's duty is to the patient, not to society or to insurers.[14-16]

In essence, then, physicians have been expected virtually to commandeer other people's money and property for the benefit of their patients. For many years such economic indifference was plausible. Insurance, both private and government, was structured to insulate patient and provider from worrying about costs.[16] Reimbursement was retrospective and usually generous, and cost-shifting (providers' practice of raising charges to paying patients in order to cover nonpaying patients) covered many of the uninsured who found their way into the health care system.

In reaction to three decades' explosive expansion in health care expenditures, however, the "economic agents" who furnish the medical and monetary resources of care are no longer willing to stand as silent partners funding whatever physician and patient choose to do. Government, business, insurers, institutional providers such as hospitals and health maintenance organizations, and virtually everyone else with a major financial stake in health care now control their resources with a striking array of cost-containment and profit-producing measures, ranging from managed care and intensive utilization review to caps on coverage and restrictions on eligibility. The physician thus finds himself or herself increasingly trapped between traditional mandates to deliver unstinting resources to patients and a progressive loss of the power to do so.[4,17] And if physicians try to avoid this predicament by becoming themselves owners of the relevant resources, they can create formidable conflicts of interest between themselves and their patients.[6]

GAMING: DEFINITION, DEVICES

While physicians have lost much of their direct control over resources, in fact they retain considerable indirect control. Where economic agents' resources rules seem to impede care, the physician can usually find ways to game the system, to bypass those rules while still appearing to honor them and thereby to secure resources that were not, technically at least, intended for this patient.

This room for manipulation has two sources. First, all resource rules leave room for interpretation. They must be articulated with language, and language is inherently vague, as it uses a limited number of verbal concepts to

capture the infinite variety of experience. Reimbursement based on diagnosis-related groups, for example, requires the physician to state the patient's diagnosis. Yet, in fact, it is often possible for the physician to describe his patient's condition in a variety of ways. The physician might describe the patient's episode as a "probable transient ischemic attach" or as a "possible stroke," depending on which will yield better reimbursement.[18-19]

Second, resource rules must leave flexibility for individuality of care. Medically, patients and their illnesses are too complex and diverse to be described adequately by any "cook-book" or computer.[2-3] And legally, insurers and hospital administrators who dared to dictate the daily details of care might be accused of practicing medicine without a license[20] or, at least, could increase their own exposure to tort liability." Therefore, they often are willing to accede to the physician who insists that a patient needs some particular intervention,[21] or at least to negotiate some mutually acceptable course of care.[22]

Between the resource rules' unavoidable vagueness and their necessary flexibility then, the creative physician can invent numerous ways to game the system. Not all manipulation of resources rules counts as gaming, of course. When resource rules are substantially ambiguous, the physician might simply select whichever fully correct description of the patient's condition will produce the most favorable application of the resource rules. For a Medicare patient with multiple medical problems, for instance, one can list renal failure rather than diabetes or hypertension as the "principal diagnosis," thereby maximizing the hospital's diagnosis-related group reimbursement.

Gaming does not begin until the physician pushes harder against a proper fit between language and reality. He may fudge, using florid descriptions to exaggerate the seriousness of the patient's condition to a utilization review officer who has been reluctant to authorize hospitalization,[21] or he or she might install an intravenous line in a patient who has no need for intravenous medication, solely to ensure such a utilization review authorization. There are many methods and degrees of fudging, short of outright lying, and many physicians have expressed willingness to resort to such tactics on occasion.[23]

At the extreme, the stretch and push of fudging merges into the flagrant dishonesty of fraud. The plastic surgeon may say that this patient's rhinoplasty was "necessitated" by a (fictitious) ski accident. The internist may file claims for tests that were never performed or for patients who do not exist, or may secure payment several times for a single procedure (*Wall Street Journal* December 6, 1989; A-1, A-8).

Gaming is not only easily available. It is now sorely tempting, because it seems to offer escape from an impossible situation by allowing physicians to secure indirectly what they no longer control directly. The physician still manages to extract the hospital admission or the costlier therapy, despite third parties' refusals or reluctance.

THE CASE FOR GAMING

Gaming is particularly tempting in two kinds of situations. First, many patients lack adequate health care coverage. Almost 40 million Americans have no medical insurance. Where formerly many of these people had at least some gratuitous entry into the health care system,

the disappearance of cost shifting has left many of these people wither in overcrowded hospitals or without care altogether. Beyond this, many insurance policies are not comprehensive. An infant recovering from meningitis may be medially ready to leave the hospital receiving oral antibiotics without, for example, but if his or her 14-year-old, illiterate mother is unlikely to adhere to the necessary outpatient regiment, the physician may want to "find" some further "medical problem" that "requires" a longer inpatient stay. The medical orientation of most insurance rules leaves little room for such medically significant social problems of for the psychosocial component of many medical problem.[24] Similarly, many physicians are disturbed by insurers' traditional refusal to cover screening tests and other important preventive care. Even insurance coverage that is basically adequate can precipitate problems. Many patients, unaccustomed to paying for medical care and now facing higher cost sharing or reduced coverage, may pressure their physicians to waive their copayments of to "get the insurance to pay" for services not covered by their policies or health maintenance organizations plans.

Second, patients do not always receive even the resources to which they are entitled. Some insurers have developed a truly awe-inspiring array of tactics by which to avoid or delay making the payments they owe.[25] In other cases an unsophisticated utilization review clerk may deny approval to reimburse hospitalization for a condition that clearly requires it, as where a patient has a clinically obvious even if atypical presentation of appendicitis. Or in some instances the physician may question the patient's health care policy at a fundamental level. A health maintenance organization may lure subscribers with promises

that "we provide all the care you'll ever need," yet fail to disclose an assortment of coverage limits, incentive systems, and barriers to care.[26-29] Where there is good reason to suspect that the payer is "gaming the patient," the physician may be sorely tempted to dodge its rules.

Note, patients are not the only ones whose needs may be ill-served by resource rules. Hospitals, too, can suffer where payers refuse to pay, or where they must care for too many indigent patients. Likewise, physicians' fees are increasingly the targets of cost containment. We can argue that physicians need to take their own incomes seriously as a moral issue,[30] and that greed can never justify gaming. We may also agree that physicians and hospitals ought to provide at least some uncompensated care for indigent patients, yet we must acknowledge that these obligations are not unlimited. It is unfair to expect providers alone to make up for the broader society's lack of a comprehensive health care system.

THE CASE AGAINST GAMING

Though gaming can be powerfully attractive in a system that leaves many patients with inadequate health care resources, and that still expects physicians generously to deliver resources that they no longer fully control, it also carries formidable moral and medical hazards. It can violate principles of nonmaleficence, veracity and justice.

Nonmaleficence is the principle of avoiding harm. Gaming can harm the very patient it is intended to help, as sadly evidenced by the case of Pauline Stafford. Even if we argue that the immediate harm to Stafford could have been avoided if the physican had explained his 'creative

accounting' system ahead of time, an important indirect harm could thereby be done to her trust for him. If he is so cheerfully willing to lie for her, perhaps he is equally willing to lie to her. Moreover, such an explanation can place the patient in a very awkward position. One who does not morally approve of such deception must either challenge the physician's integrity outright, or must be an uneasy silent accomplice to the dishonesty. Further, if a physican exaggerates the seriousness of a patient's condition to utilization review officers on the telephone, he or she may have to write those exaggerations in the chart, thus jeopardizing the patient's future care. Similarly, a phychiatrist who identifies a patient's illness according to the most serious, best-reimbursed diagnosis, he may needlessly stigmatize the patient elsewhere in life.

Other patients, too, can be directly harmed. If a physician gains entry for a patient into a crowded coronary intensive care unit by (mis)describing the patient's exertional angina as "unstable," some needier patient may be denied admission. Physicians can even hurt themselves. If an adverse medical outcome happens later to lead to litigation, even altruistically motivated fudging could undermine the physician's credibility in the eyes of a jury.

Everyone can be harmed by gaming. Where physicians routinely game their way around an undesirable resource rule instead of openly challenging it, they may help to perpetuate unwise policies. Thus, if insurers' refusal to cover reasonable screening tests is as medically and economically counterproductive as many physicians believe, surely it is better to challenge this policy than to preserve it by pretending to honor it.

Gaming also offends veracity. Virtually every act of gaming features some duplicity, for by definition gaming is an attempt to bypass resource rules while still appearing to honor them. We need not belabor the importance of honesty. It is a basic tenet of moral integrity, of respect for other persons, and of successful communication and cooperation in a community.[31] Furthermore, no resource system can long survive widespread abuse and dishonesty, nor can physicians expect to retain either their professional integrity or, equally important, their clinical autonomy, if they treat with duplicity those who own the medical and monetary resources essential to their patients' care.[22] While the wrong is blatant where the physician games for personal gain, it is also formidable when done to help the patient.[32] It is therefore, difficult to defend even the marginal duplicity of fudging, and probably impossible ever to justify outright fraud.

Finally, gaming can offend both contractual justice and distributive justice. Contractual justice concerns fair exchange, honest dealing, and keeping one's promises.[2] Here we especially note the contract between patient and payer. The patient, perhaps through his or her employer, has paid a specified amount for a designated, and limited, list of services. Admittedly, the physician plays an important role in this contract. He or she recommends medical services to the patient and often controls the patient's access to them through his power of prescription. The physician even controls the patient's access to third-party reimbursements, as insurers require the physician signature attesting to what was done, and why.

However, this does not entitle the physician to override, undermine or otherwise "correct" the contract between patient and insurer solely because he personally

has judged it to be inadequate. So long as our health care system is based on free enterprise and voluntary negotiation among competent individuals and groups, widespread gaming represents not only an assault on legitimate agreements, but an invitation to economic anarchy. Contractual justice is better served when bad contracts are openly challenged than when they are covertly undermined.

In government insurance, too, recipients' entitlements are created, also with express limits, through a kind of contract among citizens and their legislators. Where policies are unwise or inadequate they should be corrected not by a gaming that undermines both the social decision and the democratic process by which it was made but, rather, through public discussion.

Gaming can also offend distributive justice, the basic fairness with which scarce resources are allocated.[2] Scarcity means that not everyone can have everything that he or she needs. Therefore, even the fairest possible system for distributing health care resources will have unfortunate consequences in individual cases. Gaming is tempting in such cases because, if successful, it can help those individuals to avoid those consequences. Yet, if the overall distribution system is just, these individuals who extract more than their share, even for the worthwhile goal of better health, are unjustly freeloading at others' expense. If scarce resources are to be distributed fairly, all must cooperate.

Even in societies like the United States where the health care distribution system is far from just, distributive justice would still ask the physicians to refrain from gaming to gain extra resources for their own patients.

Gaming, if widespread enough, can destroy any system of resource rules. Unless the distribution system is so seriously unjust it warrants classic civil disobedience or even revolutionary overthrow, it is usually better to preserve order through that system even while one remedies its faults through open political processes.[2,3]

In sum, then, although there are powerful reasons to game resource rules where one's patient seems to be denied a needed or even entitled resource, moral principles of nonmaleficence, veracity and justice would oppose gaming. Fortunately, a better answer is available from two sources: a practical look at the actual mechanics of health care financing, and a moral reexamination of physicians' traditional fidelity obligations to their patients.

ECONOMIC PRACTICALITIES

Practically, a physician's inclination to game is often based on empirical assumptions that commonly are, in fact, incorrect. The physician may assume, for example, that a current denial of funding constitutes a permanent denial. However, in most cases this is not actually true. All utilization review systems have mechanisms for appealing lower-level decisions and, more importantly, it is rare for prospective review to result in a flat denial of funding for care that a physician seriously argues is necessary. Usually, either the physician's original plan is accepted after further discussion or else some mutually agreeable compromise is negotiated.[22]

Similarly, where funding actually is denied or unavailable, a physician may assume that further care for the patient is thereby precluded. This assumption, too, is

often erroneous, for it may be possible to find or invent alternative options. If an elderly widow is medically ready for discharge from the hospital but lacks adequate support services at home, the better remedy is to arrange for those home services, not to hold her indefinitely in a costly inpatient facility. A bit of inventiveness in recruiting family and friends can often solve the problem even in the absence of designated funds or formal programs for home care.

Even absent such alternatives, a denial of money does not entail a denial of care. When Medicare's hospital payment has been exhausted, the patient is not automatically discharged. The denial of further funding means only that continued hospitalization must be funded from somewhere else, whether by seeking money from a charitable organization, by adding to the hospital's burden of uncompensated debt, or even by expecting the patient to pay where he or she is obligated and able to do so. Similarly, a Medicaid refusal to cover well-baby care is not a denial of care to the baby, but of payment to the physician.

In these ways, the gaming that the physician may feel so urgently necessary is, as a matter of fact, quite avoidable. Gaming is often selected not because there is no other way to secure a needed resource, but because it is more obvious or convenient than searching for alternatives. Of course, there usually are alternatives: one can appeal, invent, negotiate, find money elsewhere, or provide services at no cost.

But here we encounter a major moral challenge. To demand this level of effort seems still to presume, as in our traditional view of fidelity, that the physicians are personally responsible to deliver resources to patients,

regardless of the costs to themselves or others. In the new economics of medicine, this requirement now seems untenable. We need to reexamine traditional obligations of fidelity as they concern resources.

FIDELITY RECONSIDERED

Our expectation that physicians should generously deliver other people's money and property to their patients is largely a product of history. Until relatively recently, physicians mostly had only their own care and concern to offer. As medical technologies emerged, generous third-party coverage, plus cost-shifting, generally made it possible for physicians, patients, courts and moral observers all to ignore costs. And yet, in the cold light of current resource constraints, it makes little sense to maintain this moral and economic anachronism.

The economic agents who provide health care's resources are not "intruders"[33] into the physician-patient relationship. In many ways, they make that relationship possible. The wisest, most skilled physician can do little without tools. And where the necessary tools are costly and scarce, and are owned or paid for by third parties, then physician and patient alike have an obligation to respect these agents' legitimate interests and resource restrictions.

If physicians are not obligated to deliver to their patients are that which they neither own nor control, then what do they owe? They owe what is their to give: their professional competence and loyalty as always and, in the new era of resource restrictions, their best efforts at advising and advocacy. Physicians have always owed their

patients medical advising and medical advocacy, of course, but now we must add an economic dimension, on both a clinical level and a profession-wide level.

On the clinical level, physicians need to advise their patients more closely concerning the economic changes in health care. In an important sense, patients are the "ultimate payers" for health care. As employees, they forgo salary or fringe benefits or cover the rising cost of health insurance; as consumers, they pay higher prices for products as businesses try to recoup the increasing cost of employees' health benefits; as taxpayers they see rising taxes or reduced government services as a deficit-ridden government seeks to trim what expenditures it can; as patients, they must directly pay higher copayments and deductibles and bear the medical consequences of cost-care tradeoffs. It is therefore fitting that patients play a much greater role in choosing whatever tradeoffs must be made.

To make these judgments, patients must know the price tags on their medical options. And this requires that physicians themselves become far more aware of the actual costs of care. They must be open about their own fees, and must try to learn the costs of the medications, tests, and other care they prescribe.[34] While this task may seem onerous, it is now necessary, for patients are entitled to know and to help decide the ways in which medicine's changing economics (including the conflicts of interest that this can create between patient and physician[5,35,36]) will affect their care. Where patients know more about their costs from the outset, they may even be less likely to pressure physicians inappropriately to "get the insurance to pay" for that screening test or cosmetic surgery that is expressly excluded by their policy.

Advocacy, like advising, is not a new concept in medicine. But when applied to economics, it carries some new responsibilities. Contrary to common views, advocacy does not require the physician simply to deliver resources to the patient. Rather, an advocate is "one who pleads, intercedes, or speaks for, or in behalf of, another."[37] While the physicians do not necessarily control or own the resources they seek for their patients, they can vigorously intercede on their patient's behalf.

Economic advocacy is no longer a personal favor that the physician may or may not choose to do for the patient. It is an important part of the physician's job, because otherwise the patient will have little or no access to essential monetary as well as medical resources. Thus, while we can no longer say that physicians owe their patients other people's resources, they do owe their own efforts to secure resources. The duty is now gaining recognition in commonlaw. In one case, Herbert Chew, a steel company worker who had undergone surgery, asked his surgeon, Dr Meyer, to document for his employer that Chew's absence from work was medically necessary. Meyer reluctantly agreed to have his secretary complete the necessary forms but, despite several inquiries and proddings from Chew, did not in fact send the forms until after Chew had had been fired from his job for failure to furnish that very documentation. The Maryland Court of Special Appeals noted that the physician's promise constituted an undertaking that, although perhaps gratuitously made, carried a duty to discharge the promise in a proper and timely manner.

The court also found another important basis for liability. In earlier times, the court argued, the plaintiff's claim might well have been summarily rejected, on the

basis that a physician's obligation ordinarily did not extend beyond their duty to use their best efforts to treat and cure. The traditional scope of the contractual relationship between physician and patient, however, has expanded over the years as a result of the proliferations of health and disability insurance, sick pay, and other employment benefits. Today, the patient commonly, and necessarily, enlists the aid of his or her physician in preparing claims for health and disability. Such forms ordinarily require information possessed solely by the treating physician as well as the physician's signature attesting to the bona fides of that medical information.[38 (p. 832)] The physician therefore, the court concluded, has a duty to assist the patient in such economic matters. As a profession, physicians have further duties of economic advising and advocacy, namely, to help policymakers to write medically credible resource rules and to help change those that are not. Fortunately, such advisory efforts are already underway.[2,39,40]

CONCLUSION

In the end, then, I cannot recommend gaming as a strategy for coping with the admittedly frightening changes in medicine's economics. It is short-sighted, medically and morally hazardous, and usually unnecessary. Our real moral challenge now is to explore more closely the duties – and the limits – of economic advising and advocacy. Just as physicians should not be expected to commandeer others' money and property, so is it unreasonable to expect literally limitless efforts in appealing odd resource rulings, locating new sources of funding, or providing free care. Our agenda for the future, then, must

be not only to explore more closely the new fidelity of medical ethics, but also to consider how to forge a more rational health care structure, one that will not call for physicians so constantly to battle resource rules in order to secure care for their patients.

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Policy Review

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The doctor-patient breakdown: Trouble at the core of the medical economy.

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WITH AMAZING SPEED, American medicine is evolving in uncharted directions. Managed care has transformed a "cottage industry" run by highly individualistic physicians into a far more controlled enterprise in which many other players wield major influence, both financial and professional. In the process, two medical economies with greatly differing perspectives and fortunes have emerged. Once mutually supportive, their relationship has deteriorated.

The core economy comprises the work and economic output of physicians and related professionals who diagnose and treat patients themselves. Though medical doctors are licensed and regulated, they have historically been accorded substantial autonomy and a primacy among peers, much like that accorded the captains of ships. Privileges and authority have been closely coupled with reciprocal obligations and responsibilities for both. The captain may command, but he is the last to leave the ship; physicians may give the orders, but they are not free to abandon patients or to refuse to give care in emergency circumstances. Physicians tend to work longer hours and more years than other professionals.

The peripheral economy provides the financing, management, and technology that support the care of patients. Enterprises as diverse as manufacturing drugs and writing health insurance policies all contribute to

patient care, though not independently. The face of modern medicine would be very different without this peripheral economy, but it is physicians who ultimately give the orders that are required to diagnose and treat patients.

The distinction between core and peripheral medical economies may appear to be either arbitrary or a misnomer, not least because the "peripheral" medical economy accounts for more than 80 percent of health dollars. Remarkably, until recently, the "core" earnings of physicians have remained fixed at 18 percent to 20 percent of health expenditures despite all the innovations of the past 50 years – Medicare, managed care, new technologies, and a doubling of the number of practicing physicians. The consistency of physician earnings in relation to the rest of the medical economy suggests that physicians have occupied a constant place even as the structure of health care has undergone dramatic change. The peripheral economy, meanwhile, has enjoyed remarkable success under managed care. In one fabled success story, nonprofit California Blue Cross was on the verge of insolvency in 1992 when it reinvented itself as for-profit WellPoint and went on to become a $6.77 billion corporation by 2001. The pharmaceutical industry has also enjoyed record profitability. On the other hand, Healtheon, now WebMD, failed to realize its dream of "capturing the doctor's desktop" and making itself indispensable to health care – despite the prestige and resources of its founders. And physician management companies, once Wall Street favorites, have failed spectacularly, leaving physicians skeptical of overarching controls.

But in general, the peripheral economy has been successful. And perhaps unsurprisingly, the success of the peripheral economy has provoked a backlash. State

medical associations in New York, Florida, and California are suing major managed-care insurers for a variety of practices, including take-it-or-leave-it contracting and retroactive lowering of physician fees. Frequent inflammatory statements from CEOs of Aetna and WellPoint have heightened the adversarial climate; the two companies have recently been embroiled in litigation over unfair business practices. Physicians have protested bitterly as their incomes have fallen and their autonomy has eroded in a managed-care world that blurs the roles of insurer, physician, and patient.

Ironically, managed care first emerged with the pledge to modernize and streamline medicine's cottage industry. Yet, in practice, fragmentation of authority has become pervasive. Employer associations and even individual employers sometimes set target standards – and specify dosages for medications. HMOS decide whether to pay for MRI scans, angioplasties, and bypass surgery. At the same time, alternative health practitioners – chiropractors, acupuncturists, herbalists, spiritualists, and a host of others – see more patients than all primary-care physicians and osteopaths combined. (Incongruously, many managed-care plans provide insurance coverage for a portion of this care.)

Reduced authority does not diminish physicians' legal liability. Most risk remains with the physician, rather than with the insurer or the employer who chooses and funds HMO insurance, because generally only physicians are legally empowered to direct patient care. More important, the Employee Retirement Income Security Act of 1974 (ERISA), which aimed to stimulate the growth of HMOs, continues to shield HMOs from responsibility even when there is reason to believe their actions have injured

patients. This exemption has been one of the key points of dispute in the congressional and White House wrangling over the Patients' Bill of Rights.

Is it the HMO, with its power to approve or deny payment, that is realistically at fault when coverage for care is withheld and the patient then fares poorly? Or is the physician who prescribes the treatment, but who has no authority to compel payment, responsible for the consequences? Is refusal of payment merely that – or is it tantamount to vetoing the physician's therapeutic recommendations? Passionate disagreement over such issues preoccupies the courts, the Congress, and the media. Not only is it a matter of who is in charge, but also of who should be in charge. The core medical economy and the peripheral medical economy, then, are often at odds. Yet it is hard to imagine how medicine can long be successful unless the two economies support each other. They are, however, drifting farther apart – and in certain respects, it looks like a reckoning is drawing closer by the day.

Searching for "best practices"

AT THE HEART OF THESE disputes is a concern that doctors do not entirely know what they are doing. For both financial and quality reasons, government and the managed-care industry agree that non-doctors should monitor and stimulate change in physician behavior.

There is a real basis for their distrust. John Wennberg's landmark study of "small area variation" revealed that hospital utilization for equivalent illnesses in Medicare patients was significantly higher in Boston than in New Haven. In other studies, hysterectomy and prostate surgery rates showed comparable discrepancies

from one locale to another – sometimes between adjacent towns. Angioplasty and cardiac surgery rates varied in similar fashion. In these and many other cases, there was no discernable medical reason to explain a disparity that seemed to be more a question of medical style than anything else. The physicians in question, despite their widely differing approaches, were all convinced that they were doing the right thing for their patients.

Intuitively, one would think there ought to be a "right" way, or at least a best way, to treat an infection or heart attack or to do a particular operation, but doctors seem to have trouble reaching agreement. Where treatment methods differ, are there negative consequences for patients? As medical journals considered the question, employers and insurers joined in the search for "best practices." Since employers finance their employees' health insurance, they reasoned, the employer ought to receive maximum value for his money. Insurers claim that better preventive practices and treatment yield better patient outcomes at a lower cost.

A new statistical tool – meta-analysis – aids the quest to identify the best treatments. Heretofore, it was difficult to compare one research project with another because studies are never identical; even minor differences in method make drawing conclusions difficult. Meta-analysis circumvents this problem by analyzing all published studies together, differences notwithstanding, and using statistical methods to extract useful information. Acceptance of meta-analysis is not universal, however. In one case, proponents reported unsuspected cardiac risks with two of the newer antiarthritic drugs. Opponents deny the significance of the report.

In any event, more powerful literature review has boosted the international effort to create an "evidence-based medicine." The Cochrane Collaboration, headquartered in Great Britain, coordinates input from around the world. Evidence-based medicine and best practices lead seamlessly to the creation of "clinical guidelines," templates for physicians to follow in the care of specific illnesses or clinical situations. Detractors call this cookbook medicine. Proponents praise it as state-of-the-art.

Medical specialty societies, the National Institutes of Health, as well as individual health plans and physician groups have produced several thousand guidelines. Because no guideline can encompass all cases – and because some guidelines remain more a matter of expert medical opinion than of proven fact – guidelines generally are considered advisory rather than mandatory. When medical cases end up in court, however, plaintiffs' attorneys portray clinical guidelines as immutable laws and deviation from them as malpractice.

Ironically, the original impetus to put medical practice on a sounder scientific footing, to limit variations in practice, and to improve patient outcomes came from within the medical establishment – not as a response to employers, insurers, or angry consumers. Academic physicians pioneered the application of scientific analysis to medical practice. Major journals, including the New England Journal of Medicine and the Journal of the American Medical Association, have devoted significant space to such efforts. But to their collective chagrin, the reform effort was commandeered by the employer-insurer-consumer coalitions that represent the managed-care movement. From the start, issues of quality, freedom, and money undermined the fundamental logic of this medical

revolution. The primary physician, for example, was loudly touted as the best person to decide when to make specialty referrals. After all, who knows the patient better? And who else could better understand the medical issues? Besides, hadn't research shown that specialists spend much more money than primary physicians when they treat the same illnesses? And weren't all parties in the coalition united in wanting to reduce rapidly rising medical costs? But in so designating the primary physician, the managed care movement also in effect recast that doctor's role in the system.

From personal physician to gatekeeper

FOR YEARS, the American Society of Internal Medicine had spoken For of the internist as a "personal physician," who would act as a patient's guide through the health system. It was clear that the relationship between doctor and patient would be voluntary and focused exclusively on the patient's welfare. The patient would command the total loyalty of the doctor. Managed care adopted the concept of the personal physician but changed its meaning in a major way.

The personal physician became the "gatekeeper" physician – a manufactured being with multiple loyalties extending far beyond the actual patient. Gatekeeper primary physicians were to approve referrals to appropriate specialists and authorize in-patient hospital care – all within the context of making the best use of each health plan's financial resources. As it later turned out, this often proved to be a thankless task, the primary physician serving as a barrier to consultations and treatments that patients desired but which did not fit the doctor's or health

plan's definition of medical necessity. During the patients' rights debate, a New York Times editorial praised the pending legislation because both the House and Senate versions "provide patients with prompt access to emergency care and specialists, such as pediatricians and gynecologists, without a referral from a primary care physician." Primary care case management is now seen as safeguarding the profits of insurance companies.

Many physicians worried about an inherent conflict of interest. A few chafed at being required to conserve resources without any influence on how such savings would be redirected. But none could argue that there wasn't waste in free-choice medicine. The American Academy of Family Physicians actively promoted the idea of managed care as a more rational way to maximize resources, rein in excesses found in specialty care, and bring payers and physicians closer to agreement on what constitutes good medical practice. They promoted family practitioners as the ideal primary care providers because of their wider range of services compared to internists or pediatricians. Federal and state governments allocated funds to support an increase in the proportion of primary versus specialist physicians from the one in three found in the United States to closer to two out of three, the typical ratio in other Western nations where per capita health expenditures were lower.

Initially, employers were reluctant to interfere with their employees' choice of physicians and hospitals. "Indemnity" insurance that paid a percentage of charges was the norm. In order to promote and lend respectability to a theoretically less expensive medical "system," Congress passed the HMO Act in 1973. It required businesses with more than 25 employees to offer at least one HMO option

among their health insurance choices. Physicians were promised access to more patients in return for discounted fees.

This was a marriage seemingly made in heaven. With access to discounts, employers escaped the double-digit rate of medical inflation in the 1980s. Insurers were able to limit their risk not only by securing discounts, but also by contracting with individual physicians or medical groups to supply a range of services at pre-determined rates, usually on a per-patient-per-month basis. These "capitation" payments essentially exported the insurance risk from the carriers to the physicians.

For the first time in medical history, physicians were pressed to consider the welfare of the entire population of patients served by an insurer's health plan as their collective responsibility – even if it meant not doing all they could for any individual patient. Thus, managed care began to affect medical practice on an unprecedented scale. Power passed from health professionals to insurers and coalitions of employers like the Pacific Business Group on Health.

Throughout this process, "trimming the fat in the system" was supposed to save money without harming patients. There were some notable successes. Ever since the 1946 Hill-Burton Act provided federal money for hospital construction, the number of U.S. hospitals had steadily increased to more than 7,000. Many had low occupancy rates and raised charges to offset high fixed costs. There seemed to be no political will to eliminate unnecessary beds and even less to close unnecessary facilities. As with military bases, local jobs and patronage were involved. Insurance carriers kept writing ever-larger

checks and passing on the costs to employers, who ultimately rebelled. Only then did contracting with hospitals for special rates for newly minted HMO or preferred provider organization (PPO) patients in advance of care replace paying blank-check "usual and customary charges." The result was the elimination of many surplus beds, closure of some facilities, and substantial savings. Medical inflation leveled off – for a while.

The California experience

ECONOMISTS MIGHT ARGUE that the customary laws of supply and demand also apply to physicians. If true, the relationship must be complex. According to the U.S. Census Bureau, California placed eighth in the U.S. in the per capita ratio of doctors in 1990. And yet managed care took firmest root in California – a state that did not have the greatest physician surplus, where fee discounts in exchange for volume should make the most competitive economic sense. Today, many doctors are leaving the state, which has now slipped to twelfth in doctor-patient ratio. Low pay and high living costs are cited.

Managed care is currently embattled not only with the Patients' Bill of Rights, but also with the more fundamental problem of a public tired of restrictions but unwilling to pay more for less intrusive management. Nevertheless, managed care should have considerable staying power, given its incentive structure that empowers insurers, acting on behalf of employers (and less clearly of patients), to bottom-fish the medical marketplace and pay the minimum acceptable contractual rates to physicians and other providers of care.

California Blue Cross has justified questionable practices – including unilateral retroactive fee reductions to physicians – as attempts to secure the most services from providers of care at the least cost, thereby benefiting consumers. As a result, the California Medical Association has been pursuing litigation against Blue Cross for several years. Judge David Garcia of the San Francisco Superior Court, who recently approved class action for the latest suit, noted the power imbalance between the plan and the physicians – and the threat to physicians' economic survival of not agreeing to treat the more than 2 million Blue Cross patients on Blue Cross's terms.

Until recently, employers considered nothing but price in choosing health insurance. One survey of insurance benefit managers showed that only 7 percent even considered quality of care to be a principal consideration in their choice of health plan. Physicians are incredulous that, in an age of gourmet foods, designer clothing, and custom housing, medical care has been relegated to lowest-dollar status. From the physicians' perspective, their vocation has been commoditized.

A recent study in the Archives of Internal Medicine tracked this process in San Mateo County, California, where medicine has experienced a managed-care-induced industrial revolution of sorts that has dramatically affected all aspects of medical practice. From 1993 to 1998, two very large purchaser organizations spearheaded a four-year progressive reduction in health premium rates throughout California. The Pacific Business Group on Health – comprising 45 large employers who purchase health benefits for 3 million employees, retirees, and their families – and CalPERS, the retirement fund which plays the same role for 1.2 million public employees, had

demanded and won reductions that then benchmarked the market rates for other insurers. Statewide premiums fell to 21 percent below the U.S. national average by 2000. San Mateo County, where the costs of living and of producing services are among the highest in the country, was especially impacted. The county now has the lowest cost-adjusted medical insurance payouts in the nation.

The funding gap has created a medical depression in San Mateo County, which has otherwise participated in the unparalleled wealth creation of the hitech boom. In centrally located Burlingame, the average house price is $810,000; physicians are failing to qualify for home loans. The renowned Palo Alto Medical Clinic, despite more lucrative insurance contracts than its neighbors and a well-funded foundation, was forced to stop accepting new patients for primary care in 2001 by an inability to attract new physicians to provide care.

Nearly three-fourths of the local populace now belongs to an HMO. As the least expensive non-charitable health choice, employers often offer only HMO coverage to their employees. If Medicare, Medicaid, and PPO patients are added, the number of patients treated under contract rises above 90 percent. One-third of the population is treated by the Kaiser-Permanente system, a prepaid multispecialty HMO 0 group practice. Given these numbers, only a handful of physicians do not participate in managed care. Robert Merwyn, president of Mills Peninsula Hospital in Burlingame, reports that 97 percent of patient billings at his hospital are subject to contractual discounting. Most of the remaining 3 percent of the charges are never paid.

All health providers have struggled to deliver care more economically. A majority of physicians have joined

independent practice associations (IPAS), which interface with insurance companies, negotiate payments to doctors, and set fees. Some are paid fee-for-service. Other physicians receive the per-head, per-month "capitation" payments in exchange for their agreement to provide all necessary care within their expertise around the clock. Capitation rates vary from $8 to little more than $20 monthly, except for infants and the elderly, where rates are higher.

IPAS save physicians from the Herculean task of dealing with the contracting, utilization review, and other administrative departments of multiple insurance carriers – a necessity unless the physician wants to put all his financial eggs in one or two insurance-carrier baskets. IPAS really are quasi-insurance organizations. In California, the recent Speier law has subjected them to solvency standards. With little beyond the doctors' own capital to support most of them, more than 20 IPAS filed for bankruptcy in zooo. More than half currently fail at least one of four tests of fiscal solvency, according to Daniel Zingale, director of the California Department of Managed Health Care. The CEO of one of the surviving IPAS concedes that he lacks the funds to audit the payments made by insurance carriers.

Physicians have seen their investment in IPAS disappear along with large chunks of their accounts receivable. (IPAS are less common outside California, but IPA failures in Texas, a state very medically different from California, shows that their vulnerability is not a local aberration.) IPA critics also observe that IPAS insert a layer of administration that consumes 10 percent to 15 percent of the insurance premium beyond the 20 percent

to 30 percent taken by health plans for administration and profits.

Pressure on physicians relates to physician supply, the extent of penetration of managed care, and the degree to which employers exert downward financial pressure on insurance premiums. Massachusetts, for example, has a high managed-care presence and 52 percent more physicians than the national average. Median physician earnings reported by the Massachusetts Medical Society were $219,300 in 1998, dropping to $120,600 in 2000 – and much lower than the median national physician earnings reported by the American Medical Association of $199,600 in 1997 and $194,400 in 1998. As HMO penetration increases, non-HMO insurance premiums tend to fall and financial stress is brought to bear on the system. California has six of the top 10 HMO counties in the nation, the highest being Sacramento with 75 percent penetration. San Mateo County is fourth at 72 percent.

The inefficiencies of managed care

TO WHAT DEGREE are these processes self-adjusting? Physician recruiter Martin Fletcher explains that a high managed-care presence is just as likely to undermine physician earnings in high cost-of-living areas (Boston and San Francisco) as in places where costs are low or marginal (Florida and Philadelphia). Pockets of acute distress occur when steep discounting, rapidly rising office expenses (up 61 percent in Massachusetts since 1994 after adjustment for inflation), and high cost of living combine. A physician exodus has become apparent in Boston, Buffalo, New York, and Sacramento County,

California, where the number of physicians dropped 20 percent from 1995 to 2000.

Until recently, most HMO patients were very happy. But approximately 80 percent are not ill and never experience the more burdensome restrictions of HMO care. At the same time, they benefit from low rates and freedom from paperwork, both of which are highly popular. Under California's Knox-Keene law, patient liability is limited to small co-payments, usually $5 to $15. Even if the health plan cannot pay its bills, physicians are prohibited from charging patients for care rendered but for which the physician was never paid. Nor can physicians immediately stop treatment.

Patients who are accustomed to the lower out-of-pocket costs of HMOS (which typically include prescription drug benefits) are loath to leave. A Kaiser Family Foundation survey reported in September 2001 that despite the brouhaha about patient rights, the majority of HMO patients remains satisfied. Since most of the discontent is found among the minority who use medical services more intensively, this is unlikely to change radically anytime soon.

Financial pressures normally stimulate economies, but physicians have encountered a paradox. Managed care has demanded and imposed elaborate bookkeeping, slowdowns in payments, difficult processing of patient eligibility, burdensome paperwork, and numerous bottlenecks to care, such as lengthy approval processes for individual prescriptions. Many of these provisions infantilize physicians, who must repeatedly seek permission from lesser-trained employees of health plans. The complexities also drastically raise overhead costs. Over the past two

decades, typical primary care office expenses rose from one-third to two-thirds of income, mainly due to the increased administrative demands of managed care and Medicare, both of which have been superimposed on other inflationary pressures.

Spyros Andreopoulos, former public affairs director at Stanford Medical Center, has examined the inefficiencies of managed care. California's problems are anything but unique, he writes, "a symptom of a widening national crisis driven by ill-considered actions and flawed market-driven health policies." Yet few such commentaries exist apart from the complaints of those working within the system.

Medicine has been fragmented by a maze of ever-changing contracts that may make economic sense to insurers but whose success often comes at the price of exporting additional costs and inconvenience onto physicians and patients. Given the implausibility of adhering to a dozen or more Aetna or Blue Cross or other carrier-specific drug formularies, practice guidelines, and preventive medicine schedules (and of altering them every time a patient changes insurance carriers), it appears that managed care has invented the horse – in the automobile age. Unfortunately, it is not yet politically correct to say so.

Physicians accuse managed care of not covering their costs and of "predatory pricing," while managed care responds that they are paying market rates. Blue Cross in California and Texas have aroused particular ire because of especially low payments and hard-nosed bargaining techniques, such as permitting contracts to lapse and then negotiating after enormous patient-care dislocations have

already taken place. The fee pressures of HMOS also apply to PPOS, which are misleadingly named because the preferred providers in these organizations are distinguished only by a willingness to sign the carriers' typically non-negotiable contracts.

Under the year 2000 Blue Cross PPO contract, reimbursement dropped from $5 per minute for the first five minutes to under $2 per minute for 45 minutes. For a full-hour consultation, the physician donated the last 15 minutes free of charge. Considering that office overhead for an internist generally runs at $130 to $150 hourly, it is hard to economically justify remaining in practice without creating something akin to a Medicaid mill. Other insurers also compress their fee schedules, similarly punishing physicians who spend more time with their patients or who accept complex time-consuming cases.

In California, six health plans control more than 8o percent of the market. Physicians have followed lawyers and accountants in "bulking up" to augment their negotiating clout, but unlike the Sutter Hospital Group with its statewide network of hospitals, they have not been successful in winning either substantially better rates or anything close to a pro rata share of rising health insurance premiums. The average capitation rate reached its pinnacle of $45 per patient per month in 1993, according to PriceWaterhouseCoopers. By 1999, it had fallen to $29 while the cost of living jumped 25.2 percent over the intervening six years.

"There's cost sharing between all of us – hospitals, insurers, doctors – because of growing inflation, pharmacy costs, etc.," PacifiCare spokesman Tony Salters told the Dallas Morning News. "Everyone is being affected by it."

There are some odd features to the relationship, however. Physicians in separate practices cannot bargain collectively because of anti-trust laws. They find themselves sitting at the table with far more powerful and wealthy competitors for the same dollars and, as in the story about the man who eats with a lion, discover that the lion eats first. At the moment, local lions are flexing their muscles. Stanford hospitals have canceled all HMO contracts and the University of California has cancelled its agreement to see San Mateo Medi-Cal patients. Such events make physicians nervous because they must take up the slack during contract disputes. Primary physicians become the ultimate guarantors of the system when specialty care becomes unavailable.

Some physicians, hoping to level the playing field, supported legislation by California Rep. Tom Campbell that would have allowed limited collective bargaining. The bill passed the House in 2000, surviving concerted Republican attempts to amend or undo it on behalf of the insurance industry (presaging the debate on the Patients' Bill of Rights). The Senate, however, did not act on it. In the process, the American Medical Association became convinced that its longtime Republican political allies were now so much in thrall to the insurance industry that they no longer cared about physicians. In zoo 2001, the AMA's campaign contributions to Democrats for the first time exceeded those to Republicans – and by a wide margin. This reflects an emerging reality: that the free market in which doctors compete against one another for patients is being transformed into a competition among insurance carriers that marginalizes physicians.

Managed competition vs. managed care

MOST AMERICANS RECEIVE health care on a fee-for-service basis, but a different delivery mode has been offered by the Kaiser-Permanente Plan, the nation's largest pre-paid group practice health plan that is responsible for the care of 8.1 million patients. This is the model that Stanford's Alain Enthoven had in mind when he conceived the idea of "managed competition" among a handful of integrated care systems analogous to the major automakers.

The Kaiser-Permanente structure was the original conception of "managed care," a large physician group setting its own professional standards, while financing and the provision of facilities are handled by the "Kaiser" component of the duality forged by Henry Kaiser and Dr. Sidney Garfield in the 1930S. Permanente physicians do not need formal permission to make referrals. They choose their own drug formularies and create their own preventive and treatment guidelines. In order to achieve this professional independence, the medical group went toe to toe with Henry Kaiser, who would have preferred to control what he paid for.

Apart from Kaiser-Permanente, managed care allows little or no participation by contracting physicians in setting standards for care or in choosing covered laboratories, consultants, preventive care guidelines, and formulary drugs. Typically, plans adapt guidelines like those of the Cancer Society or the Centers for Disease Control of the National Institutes of Health and implement them without external discussion. They hire pharmacy benefit managers to cut deals for the inclusion of drugs on

proprietary formularies. Physicians are then given their marching orders.

Management guru Peter Drucker, who wrote a seminal paper on the utilization of knowledge workers, would point to the lack of buy-in and participation by physicians. Neither morale nor quality of output is facilitated this way. Moreover, the managed care model that treats all physicians as essentially identical when they enter practice and then, years later, still considers them the same regardless of their achievements is unlikely to foster excellence. Likewise, with patients coming and going depending more on the results of employers' changing choices of insurance plans than on the quality of care or patient satisfaction, there seems to be little future in primary care medicine for physicians who thrive on long-term relationships. Indeed, it is hard to identify another business in which good service does not automatically lead to a loyal clientele and long-term relationships.

Managed care's impact in San Mateo County is pervasive. Most physicians are unhappy. More than half experienced actual declines in income and three-fourths failed to keep up with inflation in the 1990S. But dissatisfaction is statistically independent of falling income or medical specialty. Most physicians believe the quality of care has suffered and express frustration with their practices. Most would not want their children to become physicians. The financial and psychological data support the diagnosis of significant depression in both dollar and emotional terms.

The managed-care wars also buffeted Kaiser-Permanente. For three years, the company recorded unusual financial losses due to adverse experiences in

California and the East. According to the Archives study, San Mateo Kaiser Permanente physicians began to reflect the negativism of office-based community physicians, though to a lesser degree. They were far more likely to look with favor on their drug formulary and treatment guidelines, which they or their representatives played a part in creating. Of course, these physicians were preselected for a belief in managed care, or at least a willingness to work with it, so it is difficult to know whether non-Permanente physicians would be good job candidates for managed care in either venue. At present, there seems to be either a maladapted work force or an inappropriate system – or both.

Quality control

"THE SINGLE GREATEST error consumers make is to assume that if doctors disagree, one has to be wrong," says medical librarian Shirley Maccabee. That error also underlies the effort to "manage" medicine, to systematically identify the right way to do things and then call any deviation poor quality. In a sudden shift, employers are no longer satisfied with the lowest insurance premiums. They now want the highest quality for their money. The insurers sponsoring HMOs and PPOs now compete for recognition of the "quality" of their programs as measured by the percentage of women who get annual mammograms and Pap smears, the percentage of diabetics who see an eye doctor, and the number of patients with diseases like congestive heart failure who take specific drugs that are judged to show benefits. The privately owned National Committee for Quality Assurance (NCQA) rates plans by collecting data in a program called the Health Plan

Employer Data and Information Set (HEDIS) and makes the information available to the public online.

But such measures of quality control are problematic. Are primary physicians to hunt down people who don't want to come in? Are they to be penalized for choices made by the patient? Are checklists really a good marker for the overall quality of a physician's skill? Physicians are bewildered as non-physicians continually expand the lists and pontificate about quality, as if physicians are either too lazy or stupid to seek it themselves. It follows that the only reliable advocates for quality patient care are employers and insurers, and that their comprehension of medicine is as least as good as the physician's – so good, in fact, that they don't even need to see the patient to evaluate the quality of care.

But it's inconceivable that a doctor actually treats each patient differently according to the quality precepts of each insurer (Blue Cross backache, Aetna asthma, and Cigna congestive heart failure, for example). It would be utterly confusing to tailor each patient's care to the specific desires of his insurer. Nevertheless, statistics are collected and touted in the marketplace as proof of the quality of one insurer's product over the other. Claimed differences in the results of treatment for asthma, heart failure, or diabetes are more likely to be statistical accidents than indicators of real differences in quality rendered by the doctors seeing each plan's patients. Distortions are guaranteed because NCQA's "Quality Compass" is a marketing tool for employers with more public relations than science behind it. Absurdly, in 2000 and 2001, the NCQA reported great progress in HMO quality at the same time that public anger against HMOs

was mounting rapidly – and the average HMO stock price rose 25 percent.

Medical practice and the human beings who deliver care are surely imperfect. But does that justify shifting so much clinical, financial, and administrative control to non-physicians with enormous vested interests of their own? Should all doctors have to think and do alike in order to be considered good doctors? Should patients put their lives in the hands of physicians who are intent on polishing their report cards under the benevolent guidance of employer-insurer management? That these questions are barely debated points to one of history's greatest bait-and-switch operations. Insurers who have no commitment to any geographic area and who cancel policies at will when profits drop have been made the guardians of medical quality even at the local level. Industry now vies with government in regulating medicine, as Betty Leyerle has eloquently described in The Private Regulation of American Healthcare (M.E. Sharpe,

Whither health care?

WHERE, THEN, IS American medicine headed? If present trends continue, the widespread dissatisfaction with both income and the quality of professional life will extend the decline in applicants to medical schools beyond the nearly 30 percent drop over the past five years. With an average medical school debt of $97,400 in 1999, fewer physicians will come from the middle class because of an unfavorable risk-reward ratio. The wealthy will avoid medicine as a profession, and the need for scholarships to enlist students will grow.

Consumers and non-doctors will play a greater role, with more liberal licensure for non-physician providers of care and more consumer influence over tests and treatments. Consumers will expand self-ordering of hi-tech tests such as total body scans and will win insurance coverage when there are positive findings. Managed care will continue narrowing the role of primary physicians as nurse practitioners and physician assistants perform some of their work for lower fees. This will continue until earnings drop low enough to make primary physicians, with their greater ability to diagnose and treat, more economical than non-physician substitutes.

The use of hospitalists, hospital-based medical specialists for in-patients, will also grow and relegate most primary physicians in metropolitan areas to office practice only. Specialists will continue to dominate American medicine because of public demand for new technology (but they will not regain their former authority over fees). Owing to the use of lower-cost and lesser-trained substitutes, fewer people will have primary physicians for more than short periods. The sole exception will be patients with complex problems involving multiple specialists, in which case primary physicians will be required to integrate care.

Employers and insurance carriers will change tactics in response to anti-HMO sentiment. Health plans are already starting to distance themselves from tight control of consumer choices. Higher co-pays rather than denials of service will continue to grow. Physicians will need to contend with angry patients when their recommendations do not accord with each plan's favored approach, thereby raising out-of-pocket costs. Patients will need to contend with angry physicians as other plans follow PacifiCare's

lead in rating doctors on how low they can keep out-of-pocket costs for patients. Barring catastrophic events that drastically increase the number of uninsured from its current level of 43 million, neither Congress nor the administration will even discuss a single-payer, one-size-fits-all health system.

The outlook for the peripheral medical economy looks bright because the freedom to innovate continues. Health insurance and pharmaceutical and medical device manufacturing, unlike the provision of medical or hospital services, have escaped the price controls of the Mediplans and the major financial hits of managed care. Surging health insurance premiums – up 11 percent from 2000 to 2001 – did not significantly benefit physicians.

Most physicians face major impediments to innovation because, under managed care, compliance has greater survival value than creativity – at least in the short run. Denial of services is viewed as a strike, something most physicians do not favor. The antitrust laws significantly inhibit joint action. Some specialists, notably those in renal dialysis and cancer care, have established their own businesses and negotiate collectively for their services. Primary-care innovation is far less common and has mainly involved substituting lesser-trained personnel for doctors. Furthermore, most physicians seem to have neither interest nor aptitude in creating new business arrangements. Physician executives are increasing in number, but, lacking broad business experience and divorced from patient care, they have an uncertain future.

It appears that the closer to the patient one gets, the less desirable the job becomes, the more the risk of burnout increases, and the greater the appeal of non-medical

jobs at often higher salaries. But high-earning health care executives with an average income of $800,000, not counting deferred compensation, are reportedly seeking retirement before age 65 – also due to job pressures. Paradoxically, health care delivery has grown more dysfunctional even as medical science continues to make unprecedented gains.

As Richard Nixon once said, "Solutions are not the answer." The statement seems applicable to medicine, since no nation has produced a model health system. The U.S. has so far avoided the single-payer "solution" that is finding favor with an increasing number of frustrated physicians. Instead, U.S. medicine continues to make medicine more "businesslike." Given the trends – the majority of young physicians now taking jobs rather than setting up their own practices, increasing educational debt, less willingness to commit oneself entirely to medicine at the expense of family, and fewer opportunities to remain independent – Alain Enthoven's proposal of "managed competition" makes sense.

Enthoven envisioned the appearance of other mega-plans modeled after Kaiser-Permanente. But the Kaiser-Permanente system has not been replicated; risking capital in enterprises with limited upside potential and no good exit strategies remains unappealing. What's more, Kaiser-Permanente itself has recently withdrawn from several eastern states and closed facilities due to large financial losses.

Managed care's principal accomplishment has been a temporary slowing of surging health care expenditures. At the same time, HMO growth has stalled and physicians, patients, and their employers are all frustrated. It's

unsurprising that a system that never underwent prototype field-testing before widespread implementation is encountering so many problems. Nor is it surprising that turning a blind eye to waste, duplicative effort, and inefficiency has allowed these problems to multiply.

San Mateo County physicians overwhelmingly agreed that the quality of time spent with patients has deteriorated since the mid-1990S. Much of their time now must be spent choosing drugs that won't be rejected or require lengthy negotiation for approval, checking lists of network consultants, obtaining permission for tests and referrals, and explaining the mysteries of the system that no patient learns in advance. The regulatory hurdles divert attention from what brought the doctor to medicine in the first place and leave both parties dissatisfied. Alternative practitioners are increasingly popular partly because they have fewer distractions and can focus attention more fully on their clients.

Currently, physicians are treated almost generically in high managed care areas. Patients eventually feel the depersonalization experienced by the doctor. PacifiCare is trying to counter this with bonuses for physicians who win high marks from their patients. Whether this will inspire kinder and gentler care is an open question. At least some physicians are offended by popularity contests with insurance companies as scorekeepers. In their view, marketing becomes too important and hard-earned professional competence gets taken for granted.

Continued travel down the current managed-care road will require a new type of doctor with sufficient detachment to function comfortably in the new environment. How well the humanitarian impulses that motivate most

physicians can survive this rather dehumanizing process is unknown. It is a critically important question because doctors must be allowed to be doctors if they are to leaven their technical skills with the empathy that is needed to truly heal patients. For this to happen, the two medical economies must converge and cooperate. The biggest challenge will be to use free-market mechanisms to control costs, improve efficiency, and create a climate in which physicians and patients both can thrive.

M.D., Inc.

TO DO THIS, should doctors become corporate employees? California is one of 37 states that ban the corporate practice of medicine, meaning that non-physicians cannot be the owners of businesses in which physicians treat patients. The law is based on the premise that physicians should be free to exercise professional judgment and remain fully accountable for their actions. But this view has been increasingly challenged as antiquated, anti-efficiency, and blind to current market realities.

Economists and lawyers who wish to reverse the corporate ban see medicine as no different from other business endeavors in which corporate structure has proved useful. Strikingly, however, they have failed to investigate why Kaiser-Permanente, the nation's largest HMO, deliberately chose not to have physicians work for the Kaiser Corporation. Permanente Medical Group historian Steven Gilford explains that the doctors were ready to walk away from i years of work with Kaiser unless they were allowed to retain control of patient care and resource allocation.

Moreover, fluctuations in the business cycle – the idea of hospitals coming and going, personal and business bankruptcies afflicting providers of care, and sudden disappearance of services as corporate assets are redeployed in response to changing market conditions – is a dubious basis for health policy. Sick patients are not likely to be persuaded that the benefits of brand-name medicine are worth the risks. Nevertheless, the experience in states that do allow corporate medical practice does merit scrutiny.

The redesign of health care would benefit from a human resources approach that is free of ideological bias and ill will toward physicians. California is experiencing such growing animosity. The state's HMO czar wants consumers to know whether their doctors are facing insolvency. State Sen. Jackie Speier feels that the solvency legislation she sponsored is being perverted and will fatally undermine doctors' negotiating position with managed care if their private financial status is made public. News coverage insinuates that Speier is coddling doctors. But such coverage proceeds from the widespread (and mistaken) belief that to be pro-consumer, one must be anti-doctor.

A neutral analysis of the doctor's job and the qualities needed to perform it is essential. Efficiency studies should follow. Managed care has shunned this aspect of management because the industry perceives doctors as outside contractors whose welfare and productivity are not of direct concern. Doctors are expensive to train, however; their time would best be spent caring for patients rather than doing paperwork. In order to meet the needs of a varied public, doctors should not be expected to be clones of each other. Checklists should not replace the doctor's

brain if the doctor is to remain clinically sharp. Freedom to prescribe should permit taking advantage of the subtle differences among similar pharmaceuticals to suit the specific needs of each patient. Creativity should not be extinguished in the service of compliance. Accountability – a virtue – becomes a vice when it overwhelms the person subjected to it.

Moreover, excessive regulatory control favors large, well-funded companies and may even put smaller companies out of business without any contest in the marketplace. Since small organizations cannot spread compliance costs in dollars and manpower across a large base, overregulation threatens the economic viability of otherwise healthy solo and small-group practices. Patients who prefer this kind of care may thus experience both a decreased selection of caregivers and higher costs as regulatory expenses pad the ultimate bill.

No solutions have yet emerged because, as yet, there is no agreement on goals. Policymakers should carefully consider the long-term consequences of decoupling the medical economy from the surrounding local economy, as occurred in San Mateo County. Lethal competition among physicians, the young cannibalizing the practices of their seniors with no premium awarded for achievement and experience, promises to compromise the quality of care – as does below-cost contracting for essential services. The economics of putting caregivers at personal risk with no ability to react rapidly to sudden cost increases (such as the recent jump in malpractice premiums) must also be addressed. The emotional needs of physicians and of patients, including the ability to forge long-term relationships, should not be ignored, because they determine the ultimate acceptance of any system. And the question,

"How does being treated by a depressed doctor measure up against flying with a depressed pilot?" should be taken seriously. Most of all, a vibrant, creative, and pluralistic medical profession should not be sacrificed cavalierly.

Managed care has a great deal of work to do if it is to justify the pretension embodied in its name. Legislative assistance may be needed to redirect medical competition toward healthier ends. In the end, a failing core medical economy will not long support the massive health care edifice that surrounds it.

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FOR ARGUMENT

18

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In The
Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

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STATEMENT OF THE CASE

Introduction

Certain basic facts in this case are not in dispute. Respondent Kenneth Nord worked for Kwikset Lock for 24 years, and was last employed as a materials planner. Kwikset is a California subsidiary of the Black & Decker Corporation, headquartered in Maryland. Prior to 1997, Nord's health problems had not affected his ability to work; he had an exemplary attendance record, and had accumulated more than 700 hours of unused sick leave.

In the spring of 1997, Nord began to experience serious back problems. Although the details of his medical condition are to some degree at issue, there is no dispute that he has both degenerative disc disease and chronic myofascial (soft tissue) pain. Nord saw a number of specialists, and was directed to use powerful pain killers.

In July of 1997, Nord's treating physician ordered him to stop work until his condition improved. Nord's back condition has never gotten better, and he has not worked since the summer of 1997. When Nord stopped working in July, 1997, he had approximately one year of accumulated sick leave, vacation days and other short-term benefits.[1]

In January 1998, Nord applied for disability payments. As an employee of a Black & Decker subsidiary, Nord was an eligible employee and a participant in the Black & Decker Disability Plan. That Plan is self-funded; the company pays any approved disability claims out of its own funds. The Disability Plan ordinarily provides for

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[1] Petition Lodging L-160, L-162.

benefits in an amount equal to 40% of an employee's salary. If, however, the employee opts to pay a sufficient supplemental premium, he or she is eligible for benefits equal to 70% of his or her salary. Nord had chosen to do so.

Under the benefit plan at issue, 30 months of disability benefits are paid until 30 months after he or she leaves work to a worker who can no longer perform his or her job at Black & Decker.[2] At the end of the 30 month period, if an employee is unable to work at all, he or she is eligible for disability benefits until the age of 65.[3]

Black & Decker had contracted with MetLife to process disability claims under the Plan. Nord submitted to MetLife's office in Utica, New York, a variety of supporting materials, relying primarily on the diagnosis and medical records of his treating physicians. On February 16, 1998, MetLife rejected Nord's claim for long term disability benefits,[4] concluding that he was still able to do his job as a materials planner.

Nord requested a review of that determination. Under the terms of the contract between MetLife and Black & Decker, Nord's appeal was first considered by MetLife employees in Utica, who in turn made a recommendation to Black & Decker, the plan administrator. Nord was directed to provide to MetLife any arguments or supplementary

[2] The amount paid is subject to certain deductions and offsets. In the instant case, the total amount of disability benefits that would have been paid to Nord would have been approximately $43,000 for the thirty month period.

[3] Those benefits, of approximately $3,344 a month, would have continued until Nord reached 65. These benefits were subject to certain offsets.

[4] Petition Lodging, L-145.

materials supporting his appeal, and he sent to MetLife the results of a number of additional medical tests and other materials. MetLife asked that Nord submit to an examination by a physician hired by MetLife, Dr. Antoine Mitri, and that examination occurred on July 17, 1998.

On October 15, 1998, MetLife wrote to Black & Decker recommending that Nord's disability claim be denied, enclosing a proposed draft denial letter. On October 27, 1998, Black & Decker rejected Nord's claim, and sent him a denial letter that was essentially the same as the draft that had been prepared by the Metlife employees.[5]

In the February 16 and October 27 letters rejecting Nord's claim, MetLife and Black & Decker, respectively, explained that they had concluded that Nord could still perform his job as a materials planner. In this Court, Black & Decker stresses that it could have made accommodations in the configuration of Nord's job which would have made it possible for him to work despite his back problems. (Pet. Br. 43) In fact, however, Black & Decker did not offer to allow Nord to return to his job, and never offered to him the accommodations suggested by petitioner's merits brief. Instead, in July, 1998, when Nord's other benefits had expired, and while his appeal for disability benefits was still pending, Black & Decker decided to fire him.[6]

While his disability benefit claim was still pending, Nord also applied for disability benefits under Title II of the Social Security Act. The eligibility standards under

[5] Petition Lodging, L-156.

[6] Petition Lodging, L-163.

Title II are more stringent than the standards for the first 30 months of disability benefits under the Black & Decker Plan. In order to qualify for Title II benefits, a claimant must show not only that he or she cannot perform his regular job (the Black & Decker Plan standard for the first 30 months of disability benefits), but also that he or she cannot work at all. 42 U.S.C. § 423. On August 14, 1998, the regional office of the Social Security Administration, concluded that Nord's condition "kee[ps] you from doing your past job."[7] Nord's Title II claim was initially denied, however, on the ground that the agency believed Nord could do some "other jobs". Nord appealed that determination. In February 2000, the Social Security Administration concluded that Nord was in fact totally disabled, and could not work at all. Nord is now living on Title II benefits of approximately $1,300 a month, which are less than one-third of the benefits to which Nord would have been entitled under the Black & Decker Disability Plan.

The Medical Evaluations of Nord's Degenerative Disc Disease

During the nineteen months preceding the benefits denial, Nord was treated by a series of physicians and underwent a wide range of medical tests. Nord's primary care physician was Dr. Leo Hartman, who began treating Nord for his back condition in March 1997, and referred him to a number of specialists. Nord was diagnosed and treated for his back problems by two orthopedists, Dr. Ismael Silva and Dr. Lytton Williams. Their diagnoses were confirmed by Dr. Mumtaz Ali, a neurologist, and by

[7] Petition Lodging, L-38.

Dr. Stanley Katz, a general physician in Dr. Silva's office. The medical records reveal that Nord was examined by these physicians a total of thirty times from March 1997 through April 1998.[8] These physicians prescribed a variety of medicines, including Darvocet, a narcotic pain killer, and Flexeril, a muscle relaxant.

In March and August of 1997, at the direction of Dr. Hartman, Nord had x-rays of his lumbosacral spine. In July, 1997, Nord underwent an MRI of his lumbar spine. In November of 1997, on Dr. Hartman's recommendation, Nord underwent electrodiagnostic studies under the control of Dr. Ali.[9] These test results, as well as the records of Dr. Hartman, Dr. Ali, and Dr. Silva, were submitted to MetLife in connection with Nord's disability application. The tests all demonstrated the existence of degenerative disc disease in Nord's lower spine, a diagnosis in which all three of the physicians concurred. The tests also revealed bilateral radiculopathy, sciatica, a mild diffuse bulge, and degenerative changes in Nord's bilateral lower lumbar spine.[10]

In rejecting Nord's initial application, MetLife's February 1998 letter explained that he had failed to provide information regarding his use of pain killers and his participation in physical therapy.[11] In support of his administrative appeal, Nord provided MetLife with extensive

[8] Although Nord has remained under the care of several physicians, this is the date of the last treatment described in the record before the plan administrator.

[9] Petition Lodging, L-97-100.

[10] Petition Lodging, L-81, L-84, L-99.

[11] Petition Lodging, L-144-45.

documentation regarding both.[12] In addition, MetLife suggested that Nord's pain might be mild enough that it could be controlled by pain killers, thus permitting him to return to work. In response, Nord had two additional sets of medical tests. First, Nord underwent a lumbar discogram, which is an objective measure of the amount of pain emanating from a particular portion of the back.[13] This confirmed the severity of the pain the disc disease was causing. Second, Nord underwent a CT scan of his lumbar spine; it too confirmed the existence of degenerative disc disease.[14] In June, 1998, Nord provided copies of these additional tests to MetLife. (J.App. 20).

Also in April of 1998, both Dr. Williams and Dr. Hartman completed a physical capacity evaluation. They agreed that Nord could not sit for longer than one hour a day, and that he could not lift more than five pounds.[15] These conclusions were each sufficient to preclude Nord from returning to his job as a materials planner. The Human Resources Representative at Kwikset had earlier evaluated Nord's job and concluded that it required five to six hours a day of sitting and lifting objects weighing up to twenty pounds.[16]

Dr. Mitri, the MetLife consulting physician, did not order any further medical tests. His report was based

[12] Petition Lodging L-33-41; J.App. 24-27.

[13] Petition Lodging L-49-50. The discogram indicated a pain level of 7 (on a scale of 0-10) at L5-S1, of 6 at L4-5, and of 3 at L3-4.

[14] This test revealed both annular thinning of the intervertebral discs and a loss of disc space. (Petition Lodging L-51-52).

[15] Petition Lodging L-53, L-83; J.App. 15.

[16] Petition Lodging, L-43; J.App. 32-33.

largely on a "[r]eview of tests" which described the four tests that were done in 1997. But Mitri's report made no mention of the two additional 1998 medical tests that had been undertaken and submitted by Nord for the very purpose of supporting his administrative appeal.[17] It is unclear why Mitri was seemingly unaware of the two 1998 tests. Mitri concluded, "after reviewing the report of [Nord's] tests" and on the basis of a general physical examination, that Nord "should be able to do sedentary work with some interruption by walking in between."[18] Mitri also concluded that Nord should "never" lift objects weighing more than 15 pounds,[19] which was five pounds less than what Nord's job required.

Petitioner's Proffered Explanations for Rejecting Nord's Disability Claim

In its initial February 16, 1998, decision rejecting Nord's disability claim, MetLife set out three reasons for that decision: (1) there was no documentation of Nord's attendance in a physical therapy program, (2) there was no documentation regarding how often Nord required medication, and (3) an office note in Dr. Silva's records stated that Nord was able to tolerate the pain with medication.[20]

[17] Petition Lodging, L-44.

[18] Petition Lodging, L-45. Similarly, in another portion of his report Mitri, after referring only to the 1997 tests, stated that there was "[n]o evidence on . . . test[s] to explain the patient inability to do sedentary job with occasional walking." Petition Lodging, L-48.

[19] Petition Lodging, L-48.

[20] Petition Lodging, L-144-45.

As we explain below, the Black & Decker October 27, 1998, letter rejecting Nord's appeal contained no statement of its reasons for that decision. In the litigation that ensued, however, counsel for the company has proffered a number of different justifications for the rejection of Nord's claim.

In its memoranda in support of Black & Decker's motion for summary judgment, petitioner's counsel set out the following proposed explanations for the company's decision: (1) Nord's pain could be sufficiently controlled by medication so that he could do his job,[21] (2) Nord could sit for the requisite number of hours a day if he stood intermittently,[22] (3) Nord could sit for the requisite number of hours a day if he walked intermittently,[23] (4) the limitations on Nord's ability to lift objects did not matter because his work was "primarily a desk job,"[24] (5) the treating physicians had not provided a written evaluation "that specifically addresses all of the medical tests,"[25] (6) the statements from the treating physicians did not evaluate the specific physical requirements of Nord's job,[26] and (7)

[21] Memorandum of Points and Authorities In Support of Motion for Summary Judgment (filed February 7, 2000) ("February 7 Memorandum"), pp. 1, 11, 12.

[22] February 7 Memorandum, p. 1, 12.

[23] February 7 Memorandum, p. 11, 12.

[24] Defendant's Memorandum of Points and Authorities (filed February 14, 2000) ("February 14 Memorandum"), p. 17 n. 7. This explanation was important because petitioner's Human Resources Representative had stated that Nord's job required him to lift 20 pounds, but Dr. Mitri had concluded that Nord could not lift more than 15 pounds. *See* p. 7, *supra*.

[25] February 14 Memorandum, p. 23.

[26] *Id.*

the treating physicians had merely filled out a form describing Nord's disabilities, but had not provided "a reasoned conclusion that he cannot perform his job."[27] In its brief in the court of appeals, counsel for Black & Decker relied on only the first and last of these reasons.[28]

Finally, in its merits brief in this Court, counsel for Black & Decker now identify a total of seven possible reasons for rejecting Nord's claim: (1) the treating physician's evaluation of Nord's disabilities did not indicate whether they had taken into consideration the effect of pain medication (Pet. Br. 37, 43, 44), (2) the notes of the treating physicians were illegible (Pet. Br. 2 n. 2), (3) the treating physicians were not experts in back problems (Pet. Br. 33-38, 47), (4) the treating physicians were not experts in evaluating work capacity (Pet. Br. 35), (5) the treating physicians did not know the job requirements for a materials planner (Pet. Br. 35, 36, 44), (6) the treating physicians did not take into consideration possible accommodations Black & Decker might have provided to Nord at his job (Pet. Br. 37, 43, 44), and (7) treating physicians are generally unreliable because they falsify records to assist their patients (Pet. Br. 14, 29-33).

SUMMARY OF ARGUMENT

I. The decision of the court of appeals does not require ERISA plan administrators to give any particular amount of weight to the medical opinion of a claimant's

[27] *Id.*

[28] Appellee's Answering Brief, Nord v. Black & Decker Disability Plan, No. 00-55689 (9th Cir.), pp. 4, 15-18.

treating physician. The Ninth Circuit held only that where a plan administrator rejects a claim that was based on such a medical opinion, the administrator must give "specific, legitimate reasons for doing so that are based on substantial evidence in the record." (Pet. App. 13).

II. The obligation of an ERISA plan administrator to give specific reasons for rejecting a benefits claim does not rest on, and is not limited to cases involving, the medical opinion of a treating physician.

Section 1131(1) provides that in *all* cases the plan administrator must provide "the specific reasons for such denial, written in a manner calculated to be understood by the participant." Section 1131(1) serves a number of important purposes. The required statement of reasons gives the claimant notice of what additional information or documents may be needed for a successful or subsequent claim, and provides a basis for judicial review. The requirements of section 1131(1) cannot be satisfied by *post hoc* explanations articulated by a plan's litigation counsel.

Where a benefits claim rests primarily on the medical opinion of a treating physician, the "specific reasons" required by section 1131(1) should ordinarily explain why that medical opinion was deemed insufficient to establish the claimant's entitlement to benefits.

III. The court of appeals held that Black & Decker's failure to provide specific reasons for rejecting Nord's claim, coupled with the company's conflict of interest, required that the denial of Nord's claim be considered de novo. The Ninth Circuit's reliance on the absence of such reasons was unnecessary; the conflict of interest alone was sufficient to require de novo review.

The appropriate standard of review for a claim such as this under section 1132(a)(1)(B) turns on "principles of

trust law." *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989). "The trustee is under a duty to the beneficiary to administer the trust solely in the interest of the beneficiary." Restatement (Second) of Trusts, § 170(1). If a trustee with a direct and substantial conflict of interest makes a decision that is adverse to the interest of a beneficiary, that decision ordinarily is not valid unless it had judicial approval.

A trustee cannot usually make distributions to himself or herself, since every dollar so distributed is a dollar less available for any other beneficiary. 3 A. Scott and W. Fratcher, The Law of Trusts, § 187.6 (4th ed. 1988). Similarly, trustees cannot ordinarily buy property from or sell property to the trust; in such transactions the trustee would face a similarly serious conflict in determining the purchase price. A trustee could, however, apply to the appropriate court for approval of such a distribution or purchase. That judicial approval is analogous to de novo review.

The conflict of interest in this case was direct and substantial. Black & Decker, the plan administrator, paid all disability benefits directly out of its own funds. The claim immediately at issue would have cost the company more than $43,000. If Nord had ultimately established that he was too disabled to work at all, his benefits until age 65 would have totalled approximately $400,000.

In *Tumey v. Ohio*, 273 U.S. 510 (1927), this Court concluded that the judge who convicted Mr. Tumey had an intolerable conflict of interest because he received $12 from the fine paid by the defendant. The conflict of interest in the instant case was far more serious, and assuredly warranted de novo review of Black & Decker's decision.

ARGUMENT

I. THIS CASE DOES NOT RAISE ISSUES REGARDING WHAT WEIGHT SHOULD BE GIVEN BY AN ERISA PLAN ADMINISTRATOR TO THE MEDICAL OPINION OF A TREATING PHYSICIAN

Although petitioner and several amici refer to "*the* treating physician rule", there are – at least in the Social Security context – *two* quite distinct "treating physician" rules.

The first is essentially a procedural rule, developed by the lower courts to provide a principled, consistent standard for reviewing decisions by the Social Security Administration. Where that agency has denied a disability claim that was based on the medical opinion of a treating physician, this procedural rule requires the agency to explain why it rejected that medical opinion.[29] If the agency has failed to provide such an explanation (or if the explanation is legally insufficient, or lacks support in the record), the courts will overturn that decision. Depending on the record and procedural posture of the case, it may either be remanded to the agency for further proceedings or be resolved by the court. 42 U.S.C. § 405(g). In either event, once the court concludes that the requisite explanation is absent (or insufficient), the procedural treating physician rule drops from the case.

The Social Security Administration, on the other hand, has adopted a distinct "treating physician rule"

[29] *E.g.*, *Andrews v. Shalala*, 53 F. 3d 1035, 1041 (9th Cir. 1995); *Magallanes v. Bowen*, 881 F. 2d 747, 751 (9th Cir. 1989).

which controls the evidentiary weight to be given to the medical opinion of such a physician. Ordinarily the agency will give "more weight" to the medical opinion of a treating physician than to other medical evidence. 20 C.F.R. § 404.1527(d). In some circumstances, the agency will give such medical opinions "controlling weight." 20 C.F.R. § 404.1527(d)(2). This evidentiary treating physician rule is applied by the agency before any judicial proceedings occur, and governs the agency's own actions, not any standard of review.[30]

In the instant case the treating physician rule applied by the Ninth Circuit to ERISA cases is the procedural rule, not the evidentiary rule. The court of appeals emphatically did not hold that ERISA plan administrators must give controlling, great, or any particular level of weight to the medical opinions of treating physicians. The decision below merely requires, where a benefit claim is grounded on such a medical opinion, that a plan administrator provide a reason for rejecting that medical opinion. As we explain below, such a procedural rule is clearly mandated by the terms of ERISA itself.

[30] It would, of course, be possible to articulate a justification for one of the rules that would also provide support for the other. Thus the Social Security Administration's explanation for its self-imposed evidentiary rule, that treating physicians "are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the] medical impairment(s)," 20 C.F.R. § 404.1527(d)(2), might help to persuade the courts that it would be sensible to adopt the procedural treating physician rule in reviewing decisions by the Social Security Administration or others. Regardless of whether they might be justified on similar grounds, the evidentiary and procedural treating physician rules are assuredly distinct doctrines raising decidedly different legal issues.

Several amici argue at length that this Court should not impose the evidentiary treating physician rule on ERISA plan administrators. But the appropriateness of the evidentiary rule under ERISA was not decided by the court below, and is not presented by the instant case. The extent to which these briefs depart from the question actually presented in this case is well illustrated by the brief for the United States. The government correctly observes that under the Ninth Circuit decision

> the treating physician rule requires a plan administrator "who rejects [the treating physician's] opinions to come forward with specific reasons for his decision, based on substantial evidence in the record."

(U.S.Br. 16-17, *quoting Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F. 3d 1130, 1139 (9th Cir. 2001), *petition for cert. pending*, No. 01-1840). This accurate characterization of the decision below is quite different from the government's description of the issue actually addressed by the government's brief.

> This case presents the question whether the administrator of a disability plan covered by . . . ERISA . . . is required, when deciding whether a claimant is disabled, to give special weight to the opinion of the claimant's treating physician.

(U.S.Br. 1).

Petitioner has framed the Question Presented in a manner which artfully blends elements of the two different treating physician rules. It asks the Court to decide whether the Ninth Circuit

> erred in holding that . . . the plan administrator is required to accept a treating physician's opinion of disability as controlling unless the plan administrator rebuts that opinion in writing based upon substantial evidence on the record.

(Petition, i). But the court below does not require plan administrators "to accept a treating physician's opinion," but only insists that they explain their reasons for not doing so.

Neither the petitioner, the government, nor any other amici proffer any explanation of why, in a case involving the procedural treating physician rule, this Court should pass on whether the evidentiary treating physician rule should be applied under ERISA. Given the procedural posture of the instant case, it is at best unclear whether adoption (or rejection) of the evidentiary rule would affect the outcome of this case. That question assuredly should not be addressed in a case, such as this, in which it was never determined by the court of appeals below. Although many of those briefs are directed at language in the Ninth Circuit's opinion in *Regula*, even that decision cannot fairly be read to impose the evidentiary treating physician rule on ERISA plan administrators.

II. AN ERISA PLAN ADMINISTRATOR, IN REJECTING ANY BENEFITS CLAIM, INCLUDING A CLAIM BASED ON THE MEDICAL OPINIONS OF A TREATING PHYSICIAN, MUST STATE SPECIFIC REASONS FOR DOING SO

The court of appeals correctly concluded that the plan administrator in the instant case was obligated to state specific reasons for rejecting the medical opinions of Nord's treating physicians. However, the Ninth Circuit's reliance on the procedural treating physician rule, indeed its reliance on the existence of a treating physician's medical opinion, was unnecessary. Section 503(1) of ERISA, as well

as the implementing regulations, require that in *all* cases in which benefits have been denied the plan administrator must set forth "the specific reasons for such denial." 29 U.S.C. § 1133(1).

A. ERISA and the Department of Labor Regulations Require In Every Case that a Plan Administrator State "Specific Reasons" for Rejecting a Benefits Claim

(1) The text of ERISA itself expressly requires that a written explanation be provided whenever a claim for benefits is denied.

> In accordance with the regulations of the Secretary, every benefit plan shall – (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth *the specific reasons* for such denial, written in a manner calculated to be understood by the participant.

29 U.S.C. § 1133 (Emphasis added). The Department of Labor regulations require both that specific reasons be given for the initial denial of a benefits claim, 29 C.F.R. § 2560.503-1(f)(1) (1981),[31] and that such reasons be given if an appeal of that denial is rejected. 29 C.F.R. § 2560.503-1(h)(3) (1981).[32] The regulations make no reference to the existence of a treating physician's conclusions regarding the claimant's diagnosis, prognosis, or functional capacity (*see* Pet. Br. 25-26), because the statement of reasons is

[31] This requirement is now in section 2560.503-1(g)(i).

[32] This requirement is now in section 2560.503-1(j)(1).

required in *all* cases, regardless of whether the claimant even has a treating physician.

The statement of reasons must be sufficient to impart a meaningful understanding of the basis of the adverse decision. The statute specifies that the explanation must be clear enough to be "understood by the participant." The regulation requires that the explanation set out "[t]he specific reason or reasons for the adverse determination." Thus if the plan administrator has several grounds for rejecting a claim, all of them must be disclosed.[33] Merely referring to a relevant plan provision is not sufficient; the Secretary's guidelines for claim procedures insist that the notice must set out *why* that provision resulted in a denial of benefits.[34]

The mandated statement of reasons serves several important purposes. First, by alerting a claimant to the inadequacy of his claim as it stands, the statement of reasons accords that claimant an opportunity to correct that defect, either by way of further appeal or through a renewed application for benefits.[35] Second, if an employer

[33] *See White v. Aetna Life Insurance Co.*, 210 F. 3d 412, 418 (D.C.Cir. 2000) (overturning denial of benefits because plan administrator failed to disclose one of its reasons).

[34] Pet. App. 66 ("A notice that merely indicates . . . that a rule, guideline, protocol, or similar criterion may have been relied upon does not provide the claimant any specific information about the basis on which his or her claim was decided.")

[35] *Wolfe v. J.C. Penney Co.*, 710 F. 2d 388, 392 (7th Cir. 1983) (the explanation of the denial may be "essential for the participant to fully apprehend the reason for the denial and to know what deficiency must be overcome. . . . An explanation . . . would have apprised Wolfe of the reason for the denial, alerted him to the deficiency of the record accompanying his claim, and thereby aided him in building his claim with additional evidence."); *Richardson v. Central States, Southeast and*

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has denied disability benefits because it believes the worker could return to his or her job with a reasonable accommodation, a statement of that reason alerts the worker to the availability of that accommodation and the resulting opportunity to return to work. Third, the necessity for written reasons is likely over time to establish a record of decisionmaking that could be reviewed to assure that the plan administrator acts in a principled and consistent manner.[36] Later claimants could effectively object to proffered reasons that were inconsistent with explanations given in rejecting earlier claims.[37] Fourth, the statement of specific reasons

> enables the claimant to prepare adequately for appeal to the federal courts or further administrative review, and makes it possible for the courts to perform the task, entrusted to them by ERISA, of reviewing that denial.

Halpin v. W.W. Grainger, Inc., 962 F. 2d 685, 693 (7th Cir. 1992).

Southwest Areas Pension Fund, 645 F. 2d 660, 665 (8th Cir. 1981) ("The statute and the regulations were intended to help claimants process their claims efficiently and fairly.")

[36] *Richardson*, 645 F. 2d at 664 (by regularly supplying the statement of reasons required by ERISA "the Trustees may begin to build a body of precedent that will ultimately bring about a form of consistency otherwise lacking in the administration of the Fund"); *see Lang v. Long-Term Disability Plan*, 125 F. 3d 794, 799 (9th Cir. 1997) (noting sharply inconsistent reasons for terminating plan benefits).

[37] For example, if a plan administrator rejected a claim on the ground that orthopedic surgeons are more reliable than neurologists in evaluating back pain, the administrator could not reject a subsequent claim on the opposite ground. Although benefit applications and decisions are ordinarily confidential, suitably redacted copies of those documents would presumably be available through discovery.

Petitioner objects that requiring a plan administrator to give reasons for the rejection of a benefits claim would be "draconian" (Pet. Br. 47), "legalistic" (Pet. Br. 16) and "unduly heavy." (Pet. Br. 13).[38] But that is precisely what the statute and regulations require; petitioner offers no reason why this general requirement should be *in*applicable because a claimant relied on the medical opinions of a treating physician.

Petitioner urges that requiring such a statement of reasons would improperly shift to plan administrators the burden of proof regarding the propriety of a denial of benefits. (Pet. Br. 15, 38, 39, 45). This Court has not had occasion to delineate the circumstances under which a claimant or plan administrator might bear that burden of proof, and need not do so in the instant case. Even where the claimant does bear that burden of proof, requiring the plan administrator to articulate reasons for its decisions would not alter the burden of proof. *Texas Dep't of Community Affairs v. Burdine*, 450 U.S. 248 (1981) (employer's obligation to articulate reasons for disputed action does not shift burden of proof from employee).

The United States suggests that in some instances "it may be reasonably apparent" from the medical or other evidence why the plan administrator rejected a claim. (U.S.Br. 15). But neither the statute nor the Labor Department regulations authorize a court to excuse noncompliance with section 1133 based on judicial speculation, however well reasoned, about the plan administrator's

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[38] In the district court petitioner acknowledged that "[a] plan administrator abuses its discretion when it makes 'a decision without any explanation' " (February 7 Memorandum, p. 7).

unstated reasons. A court need not "scour a record in an effort to justify the plan's decision," *Halpin*, 962 F. 3d at 694, and cannot rely on *post hoc* rationalizations proffered by the plan's attorneys. However plausible such after-the-fact explanations might seem, they would satisfy neither the letter nor the purpose of the controlling statute and regulations.

The mere fact that the record before a plan administrator contained conflicting evidence does not eliminate the need for compliance with the "specific reasons" requirement. Even in the face of such a record, a plan administrator's reason for rejecting a claim might be legally insufficient; a plan administrator could not reject the medical opinion of a treating physician merely because accepting the contrary view of the company's expert would save the employer money. Even if a plan administrator's reason was entirely legitimate, disclosure of that reason could be of great importance to the claimant. If, for example, the plan administrator chose to reject the treating physician's medical opinion because it was several years old, or because a particular type of medical test had not been performed, those would be defects which the claimant could address in further or renewed administrative proceedings.

The court of appeals, consistent with most appellate courts which have addressed this issue,[39] held that the

[39] *E.g.*, *Ellis v. Metropolitan Life Ins. Co.*, 126 F. 3d 228, 232 (4th Cir. 1997); *Bellaire Gen. Hosp. v. Blue Cross Blue Shield*, 97 F. 3d 822, 828-29 (5th Cir. 1996); *Donaho v. FMC Corp.*, 74 F. 3d 894, 899 (8th Cir. 1996); *Miller v. United Welfare Fund*, 72 F. 2d 1066, 1070 (2d Cir. 1995). In *Association of Data Processing Serv. Org. v. Board of Governors of*

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specific reason articulated by a plan administrator must be supported by substantial evidence. (Pet. App. 13, 15). Petitioner repeatedly indicates agreement that this is the correct quantum of supporting evidence (Pet. Br. 28 n. 12, 41, 47), as does the United States (U.S.Br. 14) and most of the amici allied with petitioner.[40]

Elsewhere in its brief, however, petitioner appears to suggest that the reason specified by a plan administrator need not have any evidentiary basis at all. Petitioner urges, for example, that it ought to be able to reject a claim as long as it had a "good faith belief" (however groundless) that a claimant did not meet the relevant criterion. (Pet. Br. 25). But ERISA is not (like the Equal Protection Clause) merely a prohibition against decisions made with an invidious purpose; even under a deferential review it would be an abuse of discretion for a plan administrator to make a decision, however much in good faith, that lacked an evidentiary basis. The substantial evidence rule does not by itself require that a plan administrator hire its own medical expert. (*See* Pet. Br. 15, 25). There

Fed. Reserve System, 745 F. 2d 677, 683 (D.C.Cir. 1984), then Judge Scalia observed:

> "[I]n their application to the requirement of factual support the substantial evidence test and the arbitrary or capricious test are one and the same. The former is only a specific application of the latter, separately recited in the APA not to establish a more rigorous standard of factual support but to emphasize that in the case of formal proceedings the factual support must be found in the closed record as opposed to elsewhere."

[40] Brief of Delta Family-Case Disability, etc., Plan, p.10; Brief of the American Benefits Council, p. 9 n. 4, 15; Brief for Bert Bell/Pete Rozell NFL Player Retirement Plan, pp. 7, 8 n. 2. The district court also applied that standard. (Pet. App. 32).

may be fatal defects in a claimant's own evidence; when that is the case, the administrator need only point to those problems. If, on the other hand, a claimant's evidence is sufficiently competent and credible that it demonstrates (in the absence of contrary expert medical evidence) his or her entitlement to benefits, a plan administrator cannot reject the claim on the ground that it would be costly for the plan to retain the expert needed to verify the claim.

(2) The requirement that a plan administrator provide reasons for the rejection of a claim is neither triggered by nor limited to cases involving the medical opinion of a treating physician. But where, as here, the central documentation on which a claimant relies is the medical opinion of a treating physician, the notice of rejection must be sufficient to permit the claimant, and a court, to understand *why* that medical opinion was deemed insufficient. A proffered explanation cannot fairly be said to give "the specific reasons for such denial" if it provides no account of why the primary evidence offered by the claimant was inadequate. Of course, the reason might be that the evidence was irrelevant (*e.g.*, because the claimant was not covered by the plan), inherently defective (*e.g.*, a brain cancer diagnosis by a podiatrist), overcome by non-medical evidence (*e.g.*, the supposedly wheelchair-bound claimant had been photographed playing hockey), or overcome by more reliable medical evidence (*e.g.*, an additional medical test). But there has to be *some* such explanation.

The United States observes that "in an appropriate case, a plan administrator's failure to adequately address the well-reasoned and documented opinion of a physician may violate ERISA and the Secretary's regulations." (U.S. Br. 16-17). In practice such a failure will at least ordinarily

violate the statute and regulation. It assuredly did so in the instant case.

The denial letter in this case is the very epitome of a non-explanation.[41] The first paragraph promises that the administrators reasons are "noted below." (Petition Lodging, L-115). The second paragraph merely quotes the plan's definition of disability. The third, fourth, and fifth paragraphs summarize the medical opinions of Nord's treating physicians, and the results of supporting medical tests. The sixth paragraph describes Dr. Mitri's report,[42]

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[41] A similar situation was presented in *Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771 (7th Cir. 2003). A number of physicians had concluded that Hackett was too disabled to work, and Xerox had for a time paid him disability benefits. Xerox subsequently retained a Dr. Holeman, who examined Hackett and concluded that he could indeed work. Xerox then terminated the disability benefits. Neither Holeman nor Xerox explained *why* they had rejected the conclusion of the physicians who had earlier examined Hackett.

In reinstating Hackett's benefits, the court of appeals explained:

> "Dr. Holeman provided no explanation for his departure from the opinions of the previous doctors, and Xerox provided no explanation for believing Dr. Holeman's opinion over the opinions of the previous doctors. There was no weighing of the evidence for and against, and there were no articulated reasons given for Xerox's rejection of the evidence that Hackett was unable to work. Conclusions without explanation do not provide the requisite reasoning and do not allow for effective review. . . . We are left without explanation as to why Dr. Holeman's opinion is different from [that of the previous physicians.]"

315 F.3d at 775.

[42] The Mitri report itself does little to clarify the situation. The pivotal portion of Mitri's report is his conclusion that Nord "*should* be able to do sedentary work." Petition Lodging, L-45 (Emphasis added). But that seems to be no more than an assertion that *most* persons with Nord's medical conditions could do such work. As this Court noted in

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with no account (at least none intelligible to a non-physician) of how (or, equally importantly, why) that report differed from the medical opinions of Nord's physicians. The seventh paragraph recites that information provided by Nord only the day before was not "new or different"; that was incorrect, because that information included a then recent determination by the Social Security Administration that Nord was too disabled to return to his job.[43] The paragraph also asserts, without explanation, that

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Toyota Motor Corp. v. Williams, 534 U.S. 184, 200 (2002), the degree of disability caused by a given medical condition can "vary greatly from person to person." It was thus entirely possible that Mitri's conclusion that most individuals with the listed conditions could work was entirely consistent with the conclusion of the treating physicians that Nord himself was among the minority who could not.

If Mitri meant to assert that Nord could in fact do sedentary work and that his treating physicians were thus wrong in concluding Nord could not sit for more than an hour, his report offers no account whatsoever of why he had arrived at a different conclusion, or why his conclusion was the more reliable one. *See Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F. 3d 771, 774-75 & n. 3 (7th Cir. 2003).

In addition, the entire significance of the Mitri report is called into question by the fact that it makes no reference whatsoever to the two 1998 medical tests, which Nord had provided to Metlife a month before his examination by Mitri. We simply do not know (and the plan administrator could not have known) if Mitri was unaware of those medical tests (because Metlife failed to provide them to Mitri, or because Mitri had forgotten them) or simply decided to ignore them.

In any event, ERISA and the Secretary's regulations require that specific reasons for the rejection of a benefit claim be given by the plan administrator, not by a consulting physician. An administrator could, presumably, incorporate by explicit reference the reasons given by a third party, but that did not occur here.

[43] The probative significance of such an agency determination has been widely recognized. *Whatley v. CNS Insurance Companies*, 189 F. 3d 1310, 1314 (11th Cir. 1999); *Ladd v. ITT Corp.*, 148 F. 3d 753 (7th

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a report by a Black & Decker Human Resources Representative was "not sufficient to reverse our [earlier] decision."

The letter concludes that "the medical evaluation supports Mr. Nord's ability to return to work at his own occupation." This simply makes no sense. The issue before the plan administrator was not how to understand "the" medical evaluation, but which of several competing evaluations to accept. At least to a non-physician, it simply is not clear to what extent the medical opinions of Drs. Williams, Hartman and Mitri are consistent, conflicting, or complementary. There is nothing in the letter to indicate that the official who signed it understood any differences among the diagnoses and medical tests, or had identified any basis for concluding that one diagnosis or set of tests was more reliable than the others.

The insufficiency of the October 27, 1998, letter to explain the reasoning (if any) of the plan administrator is underscored by the fact that the actual text of the letter, signed by a plan official in Towson, Maryland, had largely been drafted two weeks earlier by a MetLife claims representative in Utica, New York.

As we noted in the Statement of the Case, in the years since the commencement of this litigation, Black & Decker's able counsel has proffered more than a dozen

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Cir. 1998); *Kirwan v. Marriott Corp.*, 10 F. 3d 784 (1st Cir. 1994); *LaBarge v. Life Ins. Co. of North America*, 2001 WL 109527 (N.D.Ill., Feb. 6, 2001); *Pierce v. American Waterworks Co., Inc.*, 693 F.Supp. 996 (W.D.Pa. 1988); *Ferguson v. Greyhound Retirement and Disability Trust*, 613 F.Supp. 323 (W.D.Pa. 1985).

We do not suggest that Black & Decker was *obligated* to defer to the finding of the Social Security Administration. But surely that determination was significant new support for Nord's claim.

different specific reasons for the company's October 1998 decision to deny Nord's claims. Whether all of these reasons are legitimate, or supported by substantial evidence, is at this juncture irrelevant. ERISA and the Labor Department regulations require that specific reasons be set forth in the decision of the plan administrator; that simply did not occur.

B. Where a Plan Administrator's Decision Would be Entitled to Deferential Review, that Decision Must be Reversed or Vacated if it Lacks the Required Specific Reasons

(1) In the absence of the specific reasons required by ERISA, deferential judicial review of a plan administrator's decision would not be possible. The deference which might appropriately be accorded to a particular type of judgment by a plan administrator is not deference to any decision without regard to why it was made.[44] No deference is accorded to decisions made for illegitimate reasons, or for reasons that lack the support of substantial evidence; decisions made on those unsound grounds must be overturned. The lower courts have repeatedly overturned benefit denials because the plan administrator failed to comply with section 1133.[45]

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[44] *Richardson*, 645 F. 2d at 664 ("Our concern is that we are not only asked to defer to the judgment of the Trustees, but we are also asked to do so without the benefit of a reasoned opinion.")

[45] *E.g.*, *Hackett*, *supra*; *Halpin v. W.W. Grainger, Inc.*, 962 F. 2d 685 (7th Cir. 1992); *Matuszak v. Torrington Co.*, 927 F. 2d 320 (7th Cir. 1991); *White v. Jacobs Engineering Group Long-Term Disability Benefit Plan*, 896 F. 2d 344 (9th Cir. 1989); *Richardson*, *supra*; *Rakoczy v.*

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Where a plan administrator has failed to articulate its reasons, a reviewing court cannot know whether the reason (or reasons) that were the basis for the decision in question is a reason to which deference would be appropriate. For example, it is possible in the instant case, as the court of appeals believed, that the plan administrator decided to reject Nord's claim simply to save Black & Decker money, a plainly impermissible reason. Or, the administrator may have denied the claim in reliance on the interim denial decision, which objected that Nord had failed to produce evidence demonstrating that he had been in physical therapy. A decision on that basis, though arguably legitimate, would lack substantial evidence; following that interim denial Nord provided the plan with undisputed documentation of his participation in physical therapy. Or Black & Decker officials may merely have rubber stamped the form letter that had been prepared by MetLife, without ever attempting to understand and resolve the disputes in this case.

Petitioner's counsel has hypothesized several such possible justifications. But in the absence of a statement of reasons, there is simply no way that a court can know whether a plan administrator acted for a reason that would be entitled to deference, or for a reason that would require reversal.

> "[W]e cannot accept appellate counsel's *post hoc* rationalizations for agency action"; for an agency's order must be upheld, if at all, "on the

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Travelers Ins. Co., 914 F.Supp. 166 (E.D.Mich. 1996); *Bellanger v. Health Plan of Nevada*, 814 F.Supp. 918 (D.Nev. 1993); *Brown v. Retirement Committee of Briggs & Stratton Retirement Plan*, 575 F.Supp. 1073 (E.D.Wisc. 1983).

same basis articulated in the order by the agency itself."

Federal Power Comm'n v. Texaco, Inc., 417 U.S. 380, 396 (1974) (*quoting Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 167-68 (1962)).

If in a given case a plan administrator had given a clearly illegitimate reason (*e.g.*, a desire to save money), the reviewing court, after holding that reason unlawful, would either vacate or reverse the denial of benefits. The court assuredly would not simply excise the offending reason from the written notice of denial and then defer to the sanitized (but now wholly unexplained) decision.[46] Nor would the court permit the plan's attorney to suggest some new legitimate reason, and then defer to that. Surely a plan administrator's decision that gives no reasons at all cannot be accorded greater weight than a decision which rests on a reason that is either illegitimate or lacking in evidentiary support.

This Court has repeatedly applied this principle in other areas of the law in which deferential review exists. For example, under Rule 52 of the Federal Rules of Civil Procedure, a trial judge's findings of fact will be upheld unless clearly erroneous. But if a judge's order is so vague or conclusory that an appellate court cannot understand the basis for a disputed factual finding, the trial court's decision cannot be upheld. *Kelley v. Everglades Drainage Dist.*, 319 U.S. 415, 422 (1943); *Schneiderman v. United States*, 320 U.S. 118, 129-31 (1943). Similarly, a number of decisions made by district judges are matters of discretion; but where a judge has failed to provide an adequate explanation for his or her exercise of discretion, the appellate courts may reverse or vacate that decision. Many decisions by federal administrative agencies are also entitled to deferential review; but the absence of a reasoned account for the agency's action at least ordinarily precludes judicial approval of that action.

[46] *See American Meat Inst. v. Environmental Protection Agency*, 526 F. 2d 442, 453 (7th Cir. 1975) ("If the basis stated by the agency for its decision is insufficient, we may not supply another that the agency itself has not chosen to rely on.").

(2) A statement of specific reasons when an administrative appeal is denied is also essential to assuring that the claimant has been provided the "full and fair review" guaranteed by ERISA. 29 U.S.C. § 1133(2).

Ordinarily an administrative appeal under section 1133(2) will focus on the reasons articulated by the plan administrator for rejecting the initial application. Section 1133(1) requires the administrator to set forth specific reasons for that denial, thus apprising the claimant of the issues which he or she must address in the administrative appeal. The regulations further require that the administrator must also provide the claimant with "[a] description of any additional material or information for the claimant to perfect the claim and an explanation of why such material or information is necessary." 29 C.F.R. § 2560.503-1(g)(1)(iii). Such disclosure of the issues which must be addressed on appeal is essential to the fairness of the review process.

The informal nature of ERISA administrative appeals, however, carries with it the possibility that an appeal might be rejected for reasons never raised in the initial adverse determination, a possibility that involves a considerable risk of violating the statutory requirement of fairness. The plan administrator which resolves such

appeals is not limited to simply accepting or rejecting the reasons specified for the initial denial; the administrator may consider other reasons for rejecting the claim, reasons which may relate to the original record or to additional materials submitted during the review process.

Where a plan administrator during an administrative appeal contemplates relying on such a new reason, the section 1133(1) fairness provision requires that the claimant be provided sufficient notice of that possible disposition to permit the claimant to present materials or argument in response.[47] A review process would obviously be unfair if a claimant did not learn until the issuance of the final administrative decision of the critical objection being raised to his or her claim. Such a process would deprive the claimant of any meaningful opportunity to present evidence or argument regarding the issue deemed of controlling importance by the administrator.[48]

The instant case well illustrates the potential problem. The February 16, 1998 rejection letter set forth three specific reasons for denying Nord's claims; petitioner has

[47] "[T]o be 'full and fair,' the review must provide a claimant with knowledge of the opposing party's contentions and a reasonable opportunity to meet them." *Grossmuller v. International Union, United Automobile Aerospace and Agricultural Implement Workers*, 715 F. 2d 853, 858 n. 5 (3d Cir. 1983). Disclosure is particularly critical where the plan administrator is, in effect, both the opposing party and the judge.

[48] *White v. Aetna Life Ins. Co.*, 210 F.3d 412, 417-18 (D.C.Cir. 2000) (failure to disclose basis for rejecting claim denied claimant fair opportunity to provide the information that the plan administrator deemed essential); *Gellanger v. Health Plan of Nevada, Inc.*, 814 F.Supp. 918, 922-23 (D.Nev. 1993) (overturning denial of benefits because plan administrator failed to disclose at the time of the decision one of the bases on which it was rejecting the claim).

largely abandoned any reliance on those objections. But since the commencement of this litigation, counsel for petitioner has adduced more than a dozen new possible reasons for the rejection of Nord's claims. Many of these new reasons relate to issues that were never raised, or at least openly so, during the administrative appeal. For example, Black & Decker now objects that the notes of the treating physicians were "illegible." (Pet. Br. 2 n. 2). If that argument had been raised during the administrative appeal, Nord could have arranged to have the notes transcribed. Black & Decker argues in this Court that the treating physicians in this case lacked sufficient expertise in back problems. (Pet. Br. 33-38). If that issue had been brought up during the administrative appeal, Nord could have retained a consulting physician with whatever expertise the plan administrator thought was essential.

If Nord's administrative appeal had been expressly rejected on such new grounds, that adverse determination would at least presumptively have been reversible for violating the statutory fair hearing requirement. In the absence of any specifically stated reasons for the adverse decision on appeal, however, it simply is not possible to determine whether the section 1133(2) fairness requirement was satisfied.

(3) Where a plan administrator has violated the ERISA procedural requirements, the appropriate remedy may be to remand the case to the administrator for further consideration, or to order an award (or reinstatement) of benefits. In some instances de novo review may be the

proper judicial response to that violation.[49] Where the record is complete, and it is clear that a denial on remand would ultimately have to be overturned by the courts, such a remand would serve no purpose.[50] The court may also impose penalties on the plan administrator.[51]

In most cases, as here, the ongoing award of disability benefits to a claimant remains subject to reconsideration by the plan administrator. Thus a judicial decision awarding disability benefits would not necessarily be permanent. Such an award functions, as a practical matter, much like a preliminary injunction awarding disability benefits until, and unless, the administrator reopens the matter and concludes that the claimant does not meet (because of a change of circumstances or otherwise) the requirements for such benefits.[52]

The determination of whether to make such an award, or simply to remand the case to the administrator, is ordinarily a matter within the discretion of the district court. At least ordinarily a decision to award such benefits would not be an abuse of discretion. The harms caused by a wrongful denial of benefits often cannot be undone by a retroactive monetary relief awarded long after that initial

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[49] *E.g.*, *Matuszak v. Torrington Co.*, 927 F. 2d 320, 322-23 (7th Cir. 1991).

[50] *E.g.*, *Bellanger v. Health Plan of Nevada*, 814 F.Supp. 918, 924-25 (D.Nev. 1993); *see Harman v. Apfel*, 211 F. 3d 1172, 1174 (9th Cir.), *cert. denied*, 531 U.S. 1038 (2000).

[51] *E.g.*, *Garred v. General American Life Insurance Co.*, 774 F.Supp. 1190, 1201-02 (W.D.Ark. 1991).

[52] *See Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F. 3d 771, 776-77 (7th Cir. 2003); *Halpin v. W.W. Grainger, Inc.*, 962 F. 2d 685, 697-98 (7th Cir. 1992); *Grossmuller*, 715 F. 2d at 859-60.

error. Where an out of work claimant must rely on disability benefits to meet the necessities of life, he or she may have to endure years of indigence while those benefits are wrongly being withheld. *See Schweiker v. Chilicky*, 487 U.S. 412, 415-17 (1988). A lump sum payment at the end of that period cannot erase the suffering that occurred in the interim. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (ERISA precludes extracontractual damages needed to make a claimant whole).

If the courts were routinely to remand such cases, that practice could create a substantial disincentive for plan administrators to comply with section 1133(1). In the absence of any predictable adverse consequence for violations of section 1133(1), a plan administrator might deliberately choose to give no reasons for a denial, in order to avoid the risk that an articulated reason might be held to be illegitimate or to lack substantial supporting evidence. In the absence of any stated reason, a claimant might be deterred from suing because of his or her resulting inability to assess the likelihood of prevailing in court. Even if the claimant did sue, and the court found that section 1133(1) had been violated, the plan administrator would be no worse off, and might obtain from the court's decision useful guidance regarding how on remand to frame a denial decision that the judge would regard as sound.

C. Where a Plan Administrator's Decision Subject to De Novo Judicial Redetermination Lacked the Required Specific Reasons, the Plaintiff is Entitled to Insist on Administrative Reconsideration of his or her Eligibility

The failure of an administrator to give specific reasons for an adverse determination, although a violation of ERISA, would not preclude a court from determining de novo whether a claimant was entitled to benefits. A judicial determination of that issue – in this case, for example, a decision about whether Nord is so disabled that he could not do his old job at Kwikset – would not ordinarily be affected by any procedural errors that had occurred during the earlier administrative process.[53]

But a claimant who is entitled to a de novo determination of his or her eligibility is also entitled to an administrative determination untainted by procedural error. Where the administrative determination was flawed in some manner, the claimant may choose to insist that a court proceed to make that de novo determination, but the claimant is not required to do so. If the administrative determination is tainted by procedural error, the claimant may instead ask that the case be remanded to the plan administrator for reconsideration.

There may be sound practical reasons why a claimant might choose such a remand rather than an immediate

[53] Those errors might matter if they had resulted in a limitation on the evidence which the claimant was able (or on notice that he or she needed) to put in the administrative record. In such a case, of course, the court could simply reopen the record.

(and ultimately inevitable) de novo determination. First, the claimant may conclude that there is a reasonable possibility that the plan administrator, proceeding in a manner unencumbered by procedural error, may on remand approve the claim. Second, if additional favorable evidence has become available since the earlier administrative review, a remand will afford the claimant an opportunity to supplement the record that will be before the administrator.[54] Third, even if the claimant does not prevail on remand, the plan administrator's decision may narrow the issues that will need to be litigated before the court, deciding some but not all questions in the claimant's favor.

If a claimant has already exhausted his claim in the administrative process, and review is de novo, remand should not be ordered over the objection of the claimant. ERISA requires only that a plan's administrative process be exhausted once; the failure of a plan administrator to comply with ERISA's procedural requirements cannot impose on the claimant whose procedural rights were violated an obligation to exhaust that process for a second time. In a case involving deferential review, remand may appear appropriate because a procedurally defective decision may well not include any decision to which deference could be given. But if de novo judicial determination is to occur, a remand for that reason would never be necessary.

[54] There is a division among the lower courts regarding whether a claimant may supplement the record before the court. *See Jorstad v. Connecticut General Life Ins. Co.*, 844 F.Supp. 46, 55 (D.Mass. 1994) (citing cases).

III. THE INSTANT CASE IS SUBJECT TO DE NOVO REVIEW BECAUSE THE PLAN ADMINISTRATOR HAD A DIRECT AND SERIOUS CONFLICT OF INTEREST

The appropriate disposition of this case turns on the applicable standard of judicial review. If Nord's benefits claim is subject to de novo consideration, the decision of the court of appeals should be affirmed.[55] If, on the other hand, the plan administrator's decision is entitled to some degree of deference review, the case should be remanded to the lower courts to decide whether to award disability benefits or to return the claim to the administrator for further consideration.

The court of appeals properly concluded that the claim in this case is subject to de novo judicial determination. The Ninth Circuit based this conclusion on a combination of two circumstances: the fact that the plan administrator was subject to a conflict of interest, and the administrator's failure to provide the requisite specific reasons for rejecting Nord's claims. The appellate court's reliance on the lack of that explanation was unnecessary. Petitioner did not dispute the district court's finding that there was a conflict of interest. (Pet. App. 31). The conflict of interest was entirely sufficient by itself to mandate de novo review.

[55] Having concluded that the claim in this case was subject to de novo judicial determination, the court of appeals concluded that summary judgment should be granted to Nord. As we explain *infra*, part IV, the correctness of that portion of the court of appeals' decision is not within the scope of the Question Presented.

(1) Under trust law the paramount obligation of a fiduciary is complete loyalty to the interests of the beneficiaries. "The trustee is under a duty to the beneficiary to administer the trust solely in the interest of the beneficiary." Restatement (Second) of Trusts, § 170(1). A trustee "is not permitted to place himself in a position where it would be for his own benefit to violate his duty to the beneficiaries." 2 A. Scott & W. Fratcher, The Law of Trusts § 170 at 311 (4th ed. 1987). ERISA expressly imposes that same duty. "[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries. . . . " 29 U.S.C. §§ 1104(a)(1), 1104(a)(1)(A)(i).

> Under ERISA . . . [e]mployers . . . can be ERISA fiduciaries and still take actions to the disadvantage of employee beneficiaries, when they act as employers . . . or even as plan sponsors. . . . ERISA does require, however, that the fiduciary with two hats wear only one at a time, and wear the fiduciary hat when making fiduciary decisions.

Pegram v. Herdrich, 530 U.S. 211, 225 (2000).

This Court has repeatedly noted with considerable concern the problems created when an ERISA plan administrator is subject to a conflict of interest.

> *NLRB v. Amax Coal Co.*, 453 U.S. 322 (1981), stressed that the fiduciary provisions of ERISA were designed to prevent a trustee "from being put into a position where he has dual loyalties, and, therefore, he cannot act exclusively for the benefit of a plan's participants and beneficiaries." H.R. Conf. Rep. No. 930-1280, . . . 309.

453 U.S. at 334.[56] In *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Court recognized that such a conflict of interest would affect the degree of judicial scrutiny. "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' Restatement (Second) of Trusts § 187, comment *d* (1959)." 489 U.S. at 115.

Most recently in *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2002), the Court explained that

> [i]n *Firestone Tire* itself, we noted that review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised. That last observation was underscored only two Terms ago in *Pegram v. Herdrich*, 530 U.S. 211 (2000), when we again noted the potential for conflict when an HMO makes decisions about appropriate treatment, see *id.*, at 219-20. It is a fair question just how deferential review can be when the judicial eye is peeled for conflict of interest.

122 S.Ct. at 2169 n. 15. This Court has not, however, resolved what standard of scrutiny should apply where such a conflict of interest is present. *See Firestone Tire*, 489 U.S. at 115 (Court expressly did not address the concern for impartially that was the basis of the lower

[56] *See id.* at 333-34 ("The legislative history of ERISA confirms that Congress intended in particular to prevent trustees 'from engaging in actions where there would be a conflict of interest with the fund. . . .' S.Rep. No. 93-383, pp. 31, 32 (1973).").

court's decision); *Rush*, 122 S.Ct. at 2169 n. 15 (case did not require resolution of this issue.)

In *Firestone Tire*, the United States, in a brief joined by the Solicitor of Labor, urged that de novo review was the appropriate standard where an ERISA plan administrator was subject to a serious conflict of interest.

> The inherent nature of the conflict faced by the employer-administrators of unfunded plans entails an unqualified rule of no deference in cases involving unfunded plans administered by employers. Any alternative would sow confusion in the courts and foster inconsistent enforcement of benefit rights under these plans. . . .

Brief for the United States, No. 87-1054, Firestone Tire and Rubber Co. v. Bruch, No. 87-1054, p. 22.[57] That is the standard that should be applied in the instant case.

(2) "In determining the appropriate standard of review for actions under § 1132(a)(1)(B) we are guided by principles of trust law." *Firestone Tire*, 489 U.S. at 111. Trust law deals in two quite distinct ways with a conflict of interest, depending on the seriousness of the conflict involved.

Where a trustee's action involves merely a potential conflict of interest (*e.g.*, any financial consequences for the trustee might depend on unpredictable future events over which the trustee has no control), or the financial consequences for the trustee are de minimis, the courts will

[57] *See id.* at 7 ("a 'flexible' arbitrary and capricious standard, whose rigor varies in an ad hoc basis with the appearance of bias on the part of the administrator . . . would only create confusion as to the proper standard of review. . . . [T]here is no good reason to defer to an employer's construction of the terms of an employee benefit plan when it is paying benefits out of its own pocket.").

continue to use a degree of deferential standard.[58] The existence of that conflict, however, will be a "facto[r] in determining whether there is an abuse of discretion." Restatement (Second) of Trusts, § 187 comment *d* (1959).

If, however, the trustee's personal interest in a decision is direct and substantial, trust law generally insists that someone other than that trustee must make the decision in question. "Such transactions are irrebuttably presumed to be affected by a conflict between personal and fiduciary interests. It is immaterial whether the trustee acts in good faith. . . . " Uniform Trust Code, § 802 comment.[59] Where a trustee must make a decision in which he or she has such a personal interest, the trustee ordinarily must seek advance judicial approval.[60]

[58] *See* Restatement (Second) of Trusts, § 170 comment *c* (duty of loyalty violated where trustee has "a personal interest . . . of such a substantial nature that it might affect his judgment").

[59] Bogert on Trusts, § 95, p. 342 (6th ed. 1987) ("It is a well-known quality of human nature that it is extremely difficult, or perhaps impossible, for an individual to act fairly in the interest of others whom he represents and at the same time to consider his own financial advantage. In most cases, consciously or unconsciously, he will tend to make a choice which is favorable to himself, regardless of its effect on those for whom he is supposed to be acting. . . . For the sake of protecting [beneficiaries] against this risk equity forbids the disloyal transaction and does not consider its actual merits or effects . . . ").

[60] G. Bogert and G. Bogert, The Law of Trusts and Trustees, § 543 pp. 476 ("If peculiar circumstances make it necessary to allow the trustee to act for himself as well as for the beneficiaries with regard to a particular transaction, relief can be had by an application to the court"), 590 (2d ed. 1960); Bogert on Trusts, p. 347 ("For good cause shown the courts sometimes approve the doing of an act which would otherwise be objectionable as disloyal"); Uniform Trust Code, § 802(b)(2) (normally impermissible sale between trustee and trust allowed if "the transaction was approved by the court"); Uniform Trust Powers Act, § 5

(Continued on following page)

For example, ordinarily trustees cannot make discretionary distributions to themselves. 3 A. Scott and W. Fratcher, The Law of Trusts, § 187.6 (4th ed. 1988). In such a situation, every dollar distributed to the trustee himself or herself would be a dollar less available to the other beneficiaries. Where a trust instrument authorizes distributions to a trustee, in some jurisdictions the trustee must apply to the appropriate state court for judicial approval of any such distribution.[61] A number of states have adopted statutes authorizing a court to appoint a special trustee to make decisions regarding distributions to the named trustee. *Id.*; A. Scott and W. Fratcher, The Law of Trusts: 2002 Cumulative Supplement, § 187.6.

Similarly, trustees are generally forbidden to buy property from, or sell property to, the trust. Restatement (Second) of Trusts, § 170 comment *b*. In such transactions the trustee would face a serious conflict of interest in determining the price of the sale. In the case of a sale to the trust, for example, every additional dollar paid to the trustee for the property would be a dollar less remaining for the beneficiaries. The trustee may seek judicial approval of his or her purchase from the trust, but "[t]he court will permit a trustee to purchase trust property only if in its opinion such purchase is for the best interest of the

(court, upon notice to the beneficiary, may relieve trustee of restrictions on his power); Rev. Stat. Neb. § 30-2822(2) (2001) (any transaction involved a "substantial conflict of interest" not voidable if "the transaction is approved by the court after notice to interested persons"); Utah Code Ann. § 75-7-404 (1993).

[61] *E.g.*, *Watson v. Dietz*, 702 S.W.2d 407, 408 (Ark. 1986); *Armington v. Meyer*, 236 A.2d 450, 456 (R.I. 1967); *In re Peabody's Will*, 98 N.Y.S.2d 614, 616 (A.D. 2d 1950).

beneficiary." *Id.*, comment *f*. Sales by or to a trustee are usually voidable at the request of the beneficiaries. As a practical matter, a sale of property involving the trustee and the trust will stand only if the interested beneficiaries agree with the transaction between the trustee and the trust will.

Under the plan at issue in this case, Black & Decker had the most direct and immediate conflict of interest.[62] The disability plan at issue is unfunded; all benefits are paid directly from Black & Decker's own funds. Every dollar paid to a beneficiary was a dollar out of the company's pocket. The economics of this relationship is indistinguishable from a trustee making distributions to himself. 273 U.S. at 533.

In *Tumey v. Ohio*, 273 U.S. 510 (1927), this Court held that the due process clause invalidated a fine imposed by a village mayor, acting as a judge, who was entitled to a portion of the fine paid. In that case the mayor received only $12 of a $100 fine.

> There are doubtless mayors who would not allow such consideration as $12 costs in each case to affect their judgement in it; but the requirement of due process of law in judicial procedure is not satisfied by the argument that men of the highest honor and the greatest self-sacrifice could carry it on without danger of injustice.

[62] The methods under which ERISA benefit plans are funded, and the potential financial impact on an employer-fiduciary or approval of benefit claims, vary greatly. This case does not require the Court to assess the seriousness of the conflict of interest, if any, that might exist under other plans.

273 U.S. at 532. The Court concluded that due process would also have been violated because of the likelihood that the mayor, naturally concerned with the financial interests of the village he represented, might be swayed by that concern in his adjudication of offenses.

The financial interest of the mayor and village in *Tumey* is far smaller than the interest of Black & Decker in denying Nord's benefits claim. In the instant case the disability payments to which Nord would have been entitled, and thus the cost to Black & Decker, were quite substantial. If Nord were unable to work at his regular job, he would have been entitled to thirty months of benefits with a net total value of more than $43,000. If Nord were thereafter found unable to work at all, he would have been eligible for continued benefits of approximately $40,000 a year, subject to certain offsets, for another fifteen years, until he was 65.[63] By rejecting Nord's claims, company officials saved Black & Decker approximately $400,000. That rejection enabled the company to turn a modest additional profit, since the company was able to pocket without any ensuing liability the money that Nord had for years paid to Black & Decker to obtain a higher level of disability benefits.

The duty of loyalty owed by Black & Decker employees to their employer, and to the company stockholders, would ordinarily obligate them to avoid, if possible, paying

[63] Nord would have been approximately 50 when he became eligible for long-term disability payments of $3,400 a month, subject to certain offsets. If payments had continued at that rate until Nord was 65, they would have totalled almost $400,000, in addition to the $43,000 that would have been owed for the first thirty months of disability.

such a claim.[64] At the least, they would be obligated to search diligently for any evidence or argument that could provide a plausible basis for saving the firm the considerable expense at issue, and to assess all the available information in the light and manner most favorable to Black & Decker. The duty of loyalty which those employees owed to Nord as plan fiduciaries, however, was quite the opposite.

An employer, when it acts as a plan sponsor, can fashion its benefit scheme in any way which does not violate the limited substantive prohibitions of ERISA. "[A]n employer's decisions about the content of a plan are not themselves fiduciary acts." *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000). But when an employer acts as a fiduciary, it is presumptively subject to all the constraints and remedies of trust law. Thus ERISA permits an employer to designate itself as the fiduciary administering a benefit plan, and it allows the employer to establish a plan which is wholly unfunded or under which, as a practical matter, every dollar paid out in benefits must be replaced by a dollar from the employer itself. But if an employer selects to do *both* of these things, trust law principles apply to protect the beneficiary from the very real danger

[64] The Third Circuit's description of the conflict of interest in *Bruch v. Firestone Tire and Rubber Co.*, 828 F. 2d 134 (3d. Cir. 1987), *aff'd in part and rev'd on other grounds*, 489 U.S. 101 (1989), is applicable here:

> "The plan is controlled entirely by the employer. . . . Because the plan is unfunded, every dollar provided in benefits is a dollar spent by defendant Firestone, employer; and every dollar saved by the administrator on behalf of his employer is a dollar in Firestone's pocket."

828 F. 2d at 144.

that the employer's decisions as plan fiduciary may be affected by the conflict of interest that results. In sum, trust principles give an employer a clear choice. If the employer wishes to act as the plan administrator, controlling directly how much of its money is spent on beneficiaries, its decisions as fiduciary will not be accorded deferential review. If, on the other hand, the employer wants the plan administrator to enjoy the benefits of deferential review, it must designate a plan administrator without a serious conflict of interest. An employer can choose either control or deferential review, but it cannot have both.

(3) In the absence of de novo review, litigation of ERISA claims involving a serious conflict of interest would be intolerably complex.

Black & Decker acknowledges that under *Firestone Tire* any conflict of interest requires, at the least, a more stringent application of the abuse of discretion standard. (Pet. Br. 40). But as petitioner and several supporting amici note, a requirement of more searching but still deferential review provides the lower courts with little guidance as to when erroneous benefit denials should be upheld out of deference to the plan administrator.[65] Where, as here, there is a direct and substantial conflict of interest, de novo review provides a clear and familiar standard of review.

[65] Pet. Br. 42 & n. 17; Brief of the American Benefits Council, pp. 10-11 and n. 5; Brief Amicus Curiae of the National Association of Manufacturers, p. 7 n. 12; Brief of the American Council of Life Insurers, p. 24.

Regardless of the applicable standard of review, an ERISA claimant is always entitled to prove that the fiduciary violated section 1104 because its rejection of aclaim for benefits was in fact affected by the fiduciary's own financial interest. A benefits decision tainted by *actual* bias on the part of the fiduciary could not be upheld, no matter how reasonable it might be[66]. The existence of any conflict of interest on the part of the fiduciary is likely to create a triable issue of fact as to the fiduciary's actual motives[67]. Resolution of such questions of motive would involve application of the well-developed standards for proving unlawful intent. *E.g.*, *Reeves v. Sanderson Plumbing, Inc.*, 530 U.S. 133 (2000); *Arlington Heights v. Metropolitan Housing Dev. Corp.*, 429 U.S. 252 (1977).

The sort of conflict of interest involved in this case would often be sufficient to prove actual bias. This Court noted in *Pegram*,

> A plan might lawfully provide for a bonus for administrators who denied benefits to every 10th beneficiary, but it would be difficult for an administrator who received the bonus to defend

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[66] Restatement (Second) of Trusts, § 187 comment *g*:

"The court will control the trustee in the exercise of a power where he acts from an improper even though not a dishonest motive, that is where he acts from a motive other than to further the purposes of the trust. Thus, if the trustee in exercising or failing to exercise a power does so because of . . . some interest of his own . . . the court will interpose."

[67] *Id.* ("The fact that the trustee has an interest conflicting with that of the beneficiary is a circumstance that the court may properly consider in determining whether the trustee is acting from an improper motive in the exercise of a discretionary power.") 3 A. Scott and W. Fratcher, The Law of Trusts, p. 47 (4th ed. 1988) (footnote omitted).

> against the claim that he had not been solely attentive to the beneficiaries' interests in carrying out his administrative duties.

530 U.S. at 227 n. 7. Under the plan at issue in the instant case, the plan administrator (Black & Decker) gets a bonus (equal to the size of the claimed benefit) for *every* claimant to whom it denies benefits.

Even in the absence of any conflict of interest, moreover, greater scrutiny is given to the decision of a trustee where a beneficiary's claim turns on the determination of a question of fact (i.e., how long can Nord sit without experiencing serious pain).[68] Thus, in the instant case, scrutiny of Black & Decker's decision would have to be doubly searching, a standard likely in at least some cases to amount to de novo review, and certain in all cases to pose perplexing problems of interpretation. Rather than insist that the lower courts divine what that might mean, it would be far simpler to provide for de novo review whenever a direct conflict of interest is present.

The Ninth Circuit in the instant case, as in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), applied a hybrid standard. De novo review is utilized if an employer both had a conflict of interest and also failed to explain its rejection of the treating physician's medical opinion. Other procedural violations by the plan administrator could presumably have a similar effect. This constitutes, at best, an unnecessarily complex solution to the problem. At worst it protects beneficiaries only from biased fiduciaries too inept to comply with the ERISA procedural requirements.

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[68] 3 Scott on Trusts, p. 37.

If an employer were to establish and make contributions to a funded benefit plan whose decisions it then controlled, deferential judicial review could raise troublesome tax issues. In the absence of de novo review, there would exist a class of benefit claims over which the employer would have essentially total control of whether the employee received the benefits promised by the plan. In such a situation, the employer could not fairly be said to have relinquished control of funds contributed to the plan, and a business deduction might be permissible only when funds were actually disbursed by the plan, but not for the employer's contributions to that plan.[69]

IV. THE COURT OF APPEALS' DECISION TO AWARD SUMMARY JUDGEMENT SHOULD NOT BE DISTURBED BY THIS COURT

The Ninth Circuit, correctly applying a de novo review standard, concluded that the record warranted an award of summary judgment to Nord. Although Black & Decker objects to the utilization of that standard of review, its merits brief does not contend that the Ninth Circuit misapplied the de novo standard, or that it was error to award summary judgment under that standard. The Question Presented relates only to the propriety of the (procedural) treating physician rule, and cannot fairly be understood to encompass a fact-bound dispute about whether Black & Decker adduced sufficient evidence to survive a motion for summary judgment. Petitioner did

[69] *See* B. McNeil, Non-Qualified Deferred Compensation Plans (2002).

not ask this Court to grant review of that factual controversy, which affects only the parties to the instant case.

The United States invites this Court to address that fact-bound case-specific issue. The government asks this Court to hold that the Ninth Circuit "erred" in holding that there was no genuine issue of fact regarding Nord's disability. The government does not, however, suggest that the Ninth Circuit's evaluation of the evidence was affected in some way by the procedural treating physician rule,[70] and does not explain why it believes – if indeed it does – that this fact-specific issue is fairly included within the Question Presented.

[70] Several amici suggest that the Ninth Circuit opinion concerns the weight that should be accorded to the medical opinion of a treating physician. As we explain in Part I, *supra*, the court of appeals did not address that question.

CONCLUSION

For the above reasons, the decision of the court of appeals should be affirmed.

Respectfully submitted,

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Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

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I. RESPONDENT HAS NOT OPPOSED PETITIONER'S CONTENTIONS THAT THE TREATING PHYSICIAN RULE IS INCONSISTENT WITH ERISA'S GOALS, INFRINGES ON DEPARTMENT OF LABOR AUTHORITY, IS BASED ON A FALLACIOUS PREMISE AND IS INCONSISTENT WITH THIS COURT'S DECISION IN *FIRESTONE v. BRUCH*

Petitioner argued in its opening Brief on the Merits that the Ninth Circuit's treating physician rule (1) is inconsistent with ERISA's goals of not discouraging employers from adopting disability plans or from increasing benefits, (2) infringes on the Department of Labor's ("DOL") authority over ERISA, (3) makes a fallacious assumption that a treating physician's opinion is superior to an examining or reviewing physician's opinion, and (4) is inconsistent with the standard of review established by this Court in *Firestone Tire & Rubber Co. v. Bruch*. This Court's Rule 24.2 requires Respondent's Brief to Comply with Rule 24.1(i) by containing, "The Argument, exhibiting clearly the points of fact and of law presented . . . " Respondent has not opposed any of Petitioner's arguments and apparently has no objection to them.

II. RESPONDENT HAS RAISED FOR THE FIRST TIME ISSUES WHICH WERE NOT BEFORE THE NINTH CIRCUIT, NOT IN THE OPPOSITION TO THE WRIT OF CERTIORARI AND WHICH ARE NOT IMPLICATED IN THIS WRIT

Respondent raised for the first time in his brief on the merits that (1) the Ninth Circuit's treating physician rule is procedural and, therefore, does not raise evidentiary issues regarding the weight that should be given to a treating physician's opinion, (2) Petitioner failed to give

legally sufficient reasons for its denial of benefits under 29 U.S.C. § 1131(1), and (3) an inherent conflict of interest is sufficient to cause *de novo* review.

Respondent failed to raise these issues before the Ninth Circuit. This Court has refused to hear issues which were not raised at or reached by the court below. *See Owasso Indep. Sch. Dist. v. Falvo*, 534 U.S. 426, 431 (2002) (stating that it is the Court's practice "to decide cases on the grounds raised and considered in the Court of Appeals," quoting *Bragdon v. Abbott*, 524 U.S. 624, 638 (1998)); *TRW Inc. v. Andrews*, 534 U.S. 19, 21 (2001) (stating that the Court would not reach an issue because the issue was not raised or briefed below); *Lopez v. Davis*, 531 U.S. 230, 244 n.6 (2001) (declining to address an issue that was not "raised or decided below"); *cf. United States v. Bean*, ___ U.S. ___, 123 S. Ct. 584, 586 n.2 (2002) (noting that an argument raised for the first time in the respondent's merits brief to the Court is waived).

Furthermore, Respondent did not raise these issues in his Opposition to the Petition for Writ of Certiorari. This Court's Rule 15.2, which applies to briefs in opposition to the Petition for Writ of Certiorari, provides:

> "Any objection to consideration of a question presented based on what occurred in the proceedings below, if the objection does not go to jurisdiction, may be deemed waived unless called to the Court's attention in the brief in opposition."

This Court has refused to consider issues which were not raised in the Opposition to the Writ of Certiorari. *See Lee v. Kemna*, 534 U.S. 362, 376 n.8 (2002) (deeming an argument waived because it was not raised in the respondent's opposition to the petition for certiorari); *Knowles v. Iowa*, 525 U.S. 113, 116 n.2 (1998) (finding the respondent waived an argument by failing to raise it in its brief in opposition to the petition for certiorari); *Gardebring v. Jenkins*, 485 U.S. 415, 427 n.12 (1988); *Oklahoma City v. Tuttle*, 471 U.S. 808, 815 (1985).

Finally, the Petition for Certiorari is limited to the issue of the Ninth Circuit's treating physician rule and its effect on the decision of an ERISA plan administrator; it does not include these issues which Respondent has now newly raised in his Opposition Brief. This Court's Rule 14.1(a) provides, "Only those questions set out in the petition, or fairly included therein, will be considered by the Court." This Court has refused to consider issues which are outside the issues presented by the Petition for Certiorari. *Irvine v. California*, 347 U.S. 128, 129-130 (1954) ("We disapprove the practice of smuggling additional questions into a case after we grant certiorari. The issues here are fixed by the petition unless we limit the grant, as frequently we do to avoid settled, frivolous or state law questions."); *Toyota Motor Manufacturing Company v. Williams*, 534 U.S. 184, 202 (2002).

A. The Ninth Circuit's Treating Physician Rule Is An Evidentiary Rule Which Grants Deference And Special Weight To The Opinion Of A Treating Physician

Respondent argues that the Ninth Circuit's treating physician rule is a procedural rule which does not raise issues regarding the weight of a treating physician's opinion. This argument is contrary to Respondent's argument before the district court and the Ninth Circuit. [Plaintiffs' Opposition to Defendant's Motion for Summary Judgment, p. 21; Pet. C.A. Br. 48] It is also contrary to the Ninth Circuit's decision in *Regula v. Delta Family-Care Survivorship Plan*, 266 F.3d 1130 (2001), which first applied the Ninth Circuit's treating physician rule from Social Security Administration ("SSA") cases to ERISA cases.

In Respondent's opening brief to the District Court he argued, "The court's analysis of the claim should be guided by the treating physician rule, specifically that the opinion of the treating physician receive great weight. . . . " [Plaintiff's Opposition to Defendant's Motion for Summary Judgment p. 21] In the Ninth Circuit, Respondent argued, "The court's analysis of the claim should be guided by the treating physician rule, specifically that the opinion of the treating physician receive greater weight. . . . " [Pet. C.A. Br. 48] The Ninth Circuit agreed with Respondent's requested analysis. He has now reversed course and argues for the first time that the Ninth Circuit's treating physician rule is merely procedural and does not raise issues regarding the weight of a treating physician's opinion. [Res. Br. 12]

The Ninth Circuit first held that it would apply its treating physician rule in SSA cases to ERISA cases in *Regula v. Delta Family-Care Survivorship Plan.* In *Regula,* the Ninth Circuit stated that its treating physician rule requires the plan administrator to give deference and special weight to the opinions of treating physicians:

> "The treating physician rule applied in the Social Security setting requires that the administrative law judge . . . *give deference* to the opinions of the claimant's treating physician. . . . This grant of *deference* to a treating physician's opinions increases the accuracy of disability determinations, by forcing the ALJ who rejects those opinions to come forward with specific reasons for his decision, based on substantial evidence on the record."

266 F.3d at 1139. (Emphasis added.)

In *Regula*, the Ninth Circuit also stated:

> "As in the Social Security disability context, a rule requiring plan administrators to give *special weight* to the opinions of treating physicians is a similarly common sense requirement that, while inconsistent with the exercise of absolute discretion, is perfectly consistent with the plan administrator's role in properly determining whether a particular claimant is disabled."

Id. at 1144. (Emphasis added.)

In this case, the Ninth Circuit stated that it was bound by *Regula* to apply its SSA treating physician rule to ERISA cases. [Pet. App. 10]

There is no merit to Respondent's argument that the treating physician rule is only procedural since it is contrary to his own position before the District Court and the Ninth Circuit and is contrary to the Ninth Circuit's definition of its treating physician rule. This Court should refuse to consider this issue since it is raised for the first time in this Court, is contrary to Respondent's position below, was not raised in the Opposition to the Writ of Certiorari and is not fairly included among the issues presented by the Petition for Certiorari.

B. Respondent Has Waived The Issue That Petitioner's Written Decision Did Not Meet The Requirements Of ERISA Or DOL Regulations By Failing To Raise It Before

Respondent's claim that Petitioner failed to state sufficient reasons for its denial of benefits under 29 U.S.C. § 1131 and 29 C.F.R. § 2560.503-1(h)(3) was never raised before the Ninth Circuit, was not raised in his Opposition to the Petition for Writ of Certiorari and is not fairly

included in the Writ of Certiorari before this Court. The only issue regarding the adequacy of the written decision which Respondent raised before the Ninth Circuit was Petitioner's failure to provide specific reasons for the rejection of Janmarie Forward's answer to a hypothetical question. [Appellant's Opening Brief to the Ninth Circuit p. 28] In regard to that issue, the Ninth Circuit held that, "Black & Decker was under no duty to rebut with specificity all evidence adduced by Nord to support his claim." [Pet. App. 12. fn. 7]

Furthermore, Respondent did not raise this issue in his Brief in Opposition to the Petition for Certiorari.

This Court should refuse to consider this issue since it was not raised before the Ninth Circuit, was not raised in the Opposition to the Writ of Certiorari and is not fairly included in the issues presented by the Petition for Certiorari.

C. Respondent's Contention That An Inherent Conflict Of Interest Alone Is Sufficient To Trigger *De Novo* Review Was Not Raised Before The Ninth Circuit Or In His Opposition To The Writ Of Certiorari

Respondent's argument that Petitioner had an inherent conflict of interest and, therefore, *de novo* review is proper, if not precluded by this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), is precluded because it was not argued before the Ninth Circuit and was not presented in his Opposition to the Writ of Certiorari.

Respondent's argument that Petitioner was operating under a conflict of interest confuses the difference between an inherent conflict of interest and an actual conflict of interest which affected the plan administrator's decision.

The Ninth Circuit found that Petitioner was "operating under an inherent conflict of interest" because Petitioner acted as both the funding source and the plan administrator. [Pet. App. 8] Under Ninth Circuit precedent, where there is an inherent conflict of interest, the claimant has the burden of producing material probative evidence tending to prove an actual conflict of interest which affected the plan administrator's decision. *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995). The Ninth Circuit found that its treating physician rule provided the material probative evidence tending to prove that an inherent conflict of interest was in fact an actual conflict of interest which affected the plan manager's decision.[1] Absent the Ninth Circuit's treating physician rule, there is only an inherent conflict of interest, which is not sufficient in the Ninth Circuit to trigger *de novo* review.

Respondent argued before the Ninth Circuit that Petitioner had an inherent conflict of interest and that Petitioner's administration of his claim was material, probative evidence of an actual conflict of interest. [Appellant's Opening Br. p. 29] However, he never claimed that an inherent conflict of interest, standing alone, was sufficient to trigger *de novo* review.

Moreover, Respondent did not raise this issue in his Brief in Opposition to the Petition for Certiorari.

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[1] The Ninth Circuit also said that the plan manager's contradiction of the opinion of Janmarie Forward "is not only highhanded but also certainly *some* evidence of a conflict." [Pet. App. 11] (Emphasis added.) However, the Ninth Circuit did not find that it was sufficient standing alone to support an actual conflict of interest. [Pet. App. 11]

This Court should refuse to consider this issue since it is raised for the first time in this Court and was not raised in the Opposition to the Writ of Certiorari.

III. PETITIONER PROPERLY CONCLUDED THAT RESPONDENT WAS NOT COMPLETELY UNABLE TO PERFORM THE DUTIES OF A MATERIAL PLANNER

All of the physicians – treating, examining, and reviewing – determined that Respondent suffered from mild degenerative disc disease and was experiencing pain. [L: 45-46; 49-50; 53; 73-75; 81; 84; 95; 97-99] Petitioner has never denied that Respondent has a back injury or that he suffers some back pain.

Respondent's physicians, Dr. Hartman and Dr. Williams, both filled out check-the-box Physical Capacity Evaluations for Respondent. [L: 53; 83] They both circled pre-printed choices that Respondent could sit for one hour at a time and could sit for one hour a day. Neither of them circled pre-printed choices limiting how long during a day Respondent could stand or how long during a day he could walk. They also both checked boxes that put limitations on Respondent's ability to lift more than five pounds. Respondent also relies upon an excuse-from-work slip filled out by Dr. Hartman in March 1998 which estimated that he would not be able to return before the end of the year. [L: 66]

The only physician who expressed a comprehensive opinion about Respondent's ability to perform the job of a material planner was Dr. Mitri. [L: 43-48] Dr. Mitri examined Respondent, reviewed his medical records and reviewed his job description. The Ninth Circuit found that "Dr. Mitri

opined that Nord should be able to perform sedentary work, with no material limitations in his ability to sit, while taking pain reduction medication." [Pet. App. 5] Dr. Mitri also concluded, " . . . the patient should be able to do sedentary work with some interruption by walking in between." [L: 45] Dr. Mitri's report is consistent with Respondent's statement that he did lawn care "when it needs to be done" and went fishing. [L: 139-140] Dr. Mitri's report is also consistent with medical records stating that he had "mild LS radiculopathy"[2] [L: 99], that medication helps Respondent's pain, and that he tolerates pain with medication [L: 68, 87, 89].

Respondent was asked twice by Metlife to have his treating physicians comment on Dr. Mitri's opinion regarding Respondent's ability to perform the job of a material planner. [Pet. App. 87, 88] Respondent failed to provide any information from his treating physicians rebutting Dr. Mitri's conclusion that he could perform his job. Respondent complains because Petitioner found persuasive the only medical report that concluded he was able to perform his job. However, only one report exists because, even after being asked twice, Respondent did not obtain a response to Dr. Mitri's opinion that he was able to perform the duties of a material planner.

The Plan Manager, in exercising the discretion required of him by the plan, reviewed all of the medical opinions. [Pet. App. 91, ¶ 8, ¶ 9; 93, ¶ 19] He discussed with Janmarie Forward, the human resources representative, the requirements of the job. [Pet. App. 92-3, ¶ 17] He determined that the company could accommodate

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[2] A disorder of the spinal nerve roots. Stedman's, *Medical Dictionary* (26th Ed., 1995). [Reply App. 1]

Respondent's lifting limitations in the Physical Capacity Evaluations by providing help to him for lifting. *Id.* The Plan Manager determined that the company could accommodate the sitting limitations by allowing Respondent to sit or stand at will.[3] *Id.* Based upon all of the medical opinions available to him and the reasonable accommodations the company could offer to Respondent, the Plan Manager determined that Respondent was not completely unable to perform the job of a material planner. [Pet. App. 93, ¶ 19, ¶ 20]

IV. THE NINTH CIRCUIT'S DETERMINATION THAT A MEDICAL DIAGNOSIS OF DISABILITY BY A TREATING PHYSICIAN IS EQUIVALENT TO A DETERMINATION OF INABILITY TO PERFORM A JOB IS BASED ON A FALSE PREMISE

The Ninth Circuit's holding that Petitioner should have accepted the treating physician's determination of physical impairment as equivalent to a determination of a complete inability to perform a job is based upon a fallacious premise. A medical diagnosis of disability is not equivalent to the plan requirement of a "complete inability (whether physical or mental) of a participant to engage in his regular occupation with the Employer." [L: 20; Article 6.01] A medical diagnosis of physical impairment is only the first step in determining a claimant's ability to perform a job.

[3] As this Court has said in an analogous context, " . . . it is apparent that if a person is taking measures to correct for, or mitigate, a physical or mental impairment, the effect of those measures – both positive and negative – must be taken into account when judging whether that person is 'substantially limited' in a major life activity and thus 'disabled' under the [Americans with Disabilities] Act." *Sutton v. United Air Lines Inc.*, 527 U.S. 471, 482 (1999).

A treating physician may or may not have the expertise to express an opinion regarding a claimant's ability to perform a job.

> "Physicians have the education and training to evaluate a person's health status and determine the presence or absence of an impairment. **If the physician has the expertise and is well acquainted with the individual's activities and needs, the physician may also express an opinion about the presence or absence of a specific disability. For example, an occupational medicine physician who understands the job requirements in a particular workplace can provide insights on how the impairment could contribute to a workplace disability.**" Cocchiarella, *Guides to the Evaluation of Permanent Impairment* (5th Ed. 2002), p. 8. American Medical Association Press. [Appendix 3-4]

In its regulations, the SSA refuses to accept the treating physician's opinion regarding disability as binding on the ALJ, "A statement by a medical source that you are 'disabled' or 'unable to work' does not mean that we will determine that you are disabled." 20 C.F.R. § 404.527(e)(1) (2002).

The Plan Manager in this case had to consider not only the medical opinions, but also the requirements of the job and the reasonable accommodations that the employer could offer the employee. Respondent's treating physicians did not express any opinion in regard to his ability to perform the duties of a material planner, even though MetLife twice asked Respondent to obtain the response of his treating physicians to Dr. Mitri's evaluation that he could do his job.

The Ninth's Circuit's treating physician rule in effect assumes that a treating physician's opinion of disability is equivalent to an opinion that a claimant has a complete

inability to perform a job. There is no evidentiary or logical support for that assumption and, therefore, this Court should overturn the Ninth Circuit's decision.

V. THE NINTH CIRCUIT'S TREATING PHYSICIAN RULE APPLIES A MORE STRINGENT STANDARD OF REVIEW TO ERISA PLAN ADMINISTRATOR DETERMINATIONS THAN FEDERAL COURTS APPLY TO LOWER COURT OR ADMINISTRATIVE AGENCY DETERMINATIONS

This Court said, in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), that a court should review the decision of an ERISA plan administrator where the plan provides the administrator with discretion by an abuse of discretion standard. However, the Ninth Circuit revised this Court's standard of review by requiring the plan administrator to defer to treating physicians and give special weight to their opinions by requiring the plan administrator to *rebut the opinions of treating physicians by specific legitimate reasons supported by substantial evidence*. Not only is this revision inconsistent with *Firestone*, it is also inconsistent with the standards for (1) court review of lower court decisions and (2) court review of administrative agency determinations.

A. Federal Courts Have Found No Need For A Rule Requiring Deference And Special Weight For The Opinions Of A Treating Physician In Reviewing Lower Court Decisions

The standard of review of district court decisions by appellate courts is set forth in Federal Rule of Civil Procedure 52(a) ("court/court"). That rule requires an appellate court to affirm determinations of fact by lower courts

unless they are clearly erroneous. Appellate courts review the factual determinations of federal district courts with more scrutiny than they review administrative agency determinations. *Dickinson v. Zurko*, 527 U.S. 150 (1999). In court/court review, the reviewing court must affirm a lower court's factual determinations unless it has a definite and firm conviction that an error has been committed. *United States v. United States Gypsum Co.*, 333 U.S. 364, 395 (1948).

There is no rule in federal court/court review which (1) requires the lower court to rebut the opinion of a treating physician by specific, legitimate reasons supported by substantial evidence, (2) states that failure to follow a treating physician rule is evidence of a conflict of interest by the lower court, or (3) states that failure to use a treating physician rule will be used to measure the reasonableness of a lower court's decision. The reviewing court merely reviews to determine whether the lower court "set forth the findings of fact and conclusions of law which constitute the grounds of its action." Fed. Rule Civ. Proc. 52 (a).

Federal courts are called upon to review conflicting medical determinations in a myriad of court/court cases. For example: employer liability for seaman's injuries *DeZon v. American President Lines, LTD*, 318 U.S. 660 (1943); death penalty decisions *Barefoot v. Estelle*, 463 U.S. 880 (1983); competency to stand trial *White v. Estelle*, 459 U.S. 1118 (1983), *Drope v. Missouri*, 420 U.S. 162 (1975); competency for execution *Ford v. Wainwright*, 477 U.S. 399 (1986); civil commitment *Addington v. Texas*, 441 U.S. 418 (1979); employee impairment under the Americans with Disabilities Act *Toyota Motor Manufacturing Company v. Williams*, 534 U.S. 184, 195 (2002); student impairment under the Individuals with Disabilities Education Act *Cedar Rapids*

Community School District v. Garret F., 526 U.S. 66 (1999); vacine injury compensation *Knudsen v. Sec'y of the Dept. of Health and Human Services*, 1992 U.S. Claims LEXIS 29, *19 (Fed. Cl. Dec. 17, 1992); and admissibility of evidence *Blackburn v. Alabama*, 361 U.S. 199 (1960). This Court and the federal appellate courts have found no need for a treating physician rule in those cases. There is nothing particular or special about the testimony of treating physicians in ERISA cases which compels the use of a treating physician rule by reviewing courts, particularly where reviewing courts do not use that rule in reviewing treating physician opinions in court/court cases.

B. Federal Courts Have Found No Need For A Rule Requiring Deference And Special Weight For The Opinions Of A Treating Physician In Reviewing Administrative Agency Decisions

The Administrative Procedure Act sets forth the standard governing judicial review of findings of fact made by federal administrative agencies ("court/agency"). 5 U.S.C. § 706. Courts are required by the Administrative Procedure Act to affirm federal administrative agency factual decisions if they are supported by substantial evidence on the record as a whole. In *Arkansas v. Oklahoma*, 503 U.S. 91, 113 (1992), this Court said, "A court reviewing an agency's adjudicative action should accept the agency's factual findings if those findings are supported by substantial evidence on the record as a whole. The court should not supplant the agency's findings merely by identifying alternative findings that could be supported by substantial evidence."

Federal courts have not adopted any rules in court/agency cases which (1) require an administrative agency to rebut the opinion of a treating physician by specific

legitimate reasons supported by substantial evidence,[4] (2) provide that failure to follow a treating physician rule is evidence of a conflict of interest by the agency, or (3) provide that failure to use the treating physician rule will be used to measure the reasonableness of an agency's decision. The reviewing court merely looks to see whether on the record it would have been possible for a reasonable jury to reach the administrative agency's conclusion. *Allentown Mack v. NLRB*, 522 U.S. 359, 366-367 (1997).

Federal courts are called upon to review conflicting medical determinations in numerous court/agency cases. For example, medical treatment of inmates *Washington v. Harper*, 494 U.S. 210 (1989); release from commitment *Foucha v. Louisiana*, 504 U.S. 71 (1992); and veteran's disability benefits *White v. Principi* 243 F.3d. 1378, 1381 (Fed. Cir. 2001). In none of those cases have the federal appellate courts found it necessary to have a treating physician rule.

In *Richardson v. Perales*, 402 U.S. 389, 402 (1971), an SSA disability case decided by this Court before the SSA adopted its treating physician regulations, this Court reviewed the admissibility of medical testimony in SSA cases.

> "We conclude that a written report by a licensed physician who has examined the claimant and who sets forth in his report his medical findings in his area of competence may be received as evidence in a disability hearing and, despite its hearsay character and an absence of cross-examination, and despite the presence of opposing direct medical testimony and testimony by the claimant himself,

[4] Other than the pre-1991 SSA treating physician cases.

> may constitute substantial evidence supportive of a finding by a hearing examiner adverse to the claimant, when the claimant has not exercised his right to subpoena the reporting physician and thereby provide himself with the opportunity for cross-examination of the physician."

The claimant presented the opinion of his treating physician and objected to the unsworn opinions of five other physicians that were adverse to him. This Court, in ruling that the unsworn opinions were admissible evidence to be weighed by the ALJ against the testimony of the treating physician, stated, "These are routine, standard, and unbiased medical reports by physician specialists concerning a subject whom they had seen. That the reports were adverse to Perales' claim is not in itself bias or an indication of nonprobative character." *Id.* at 404. At least in the context of that case, this Court saw no need for a treating physician rule as a guide to making its decision.

Federal courts regularly review other lower court and agency decisions which include treating physician testimony without the use of a treating physician rule. Respondent and amici in support of Respondent have not suggested any reason why federal reviewing courts have a particular need for the Ninth Circuit's treating physician rule in ERISA disability cases, but are able to function without that same rule in other medical testimony cases. In fact, reviewing courts do not need the Ninth Circuit's treating physician rule and this Court should strike it down.

VI. AMICUS AMERICAN MEDICAL ASSOCIATION'S CONTENTION – THAT SINCE 61% OF PHYSICIANS REPORT THAT THEY NEVER OR RARELY MISREPRESENT A PATIENT'S SYMPTOMS, DIAGNOSIS OR SEVERITY OF ILLNESS THAT TREATING PHYSICIANS' OPINIONS SHOULD BE AFFORDED A REBUTTABLE PRESUMPTION – IS WITHOUT MERIT

Amicus, American Medical Association ("AMA"), argues that the opinions of treating physicians should be afforded a rebuttable presumption of correctness. [AMA Br. p. 10] In support of its position, AMA cites to a statistical survey conducted by AMA's member physicians, published in AMA's journal and distributed to AMA's member physicians, Wynia, *Physician Manipulation of Reimbursement Rules for Patients.*[5] 283 J. Am. Med. Assn. 1858 (April 12, 2000). [AMA Br. p. 10] AMA reports that this study concluded that " . . . the majority of physicians surveyed (61%) reported that they never or rarely misrepresented a patient's symptoms, diagnosis, or severity of illness, even to obtain 'coverage for care that the physicians perceive to be **necessary**' (emphasis added.)" [AMA Br. p. 17] AMA argues that this statistical survey proves that a majority of its member doctors are reliable and supports a rebuttable presumption in ERISA cases in favor of the treating physician's opinion. [AMA Br. pp. 10, 17]

Taking the survey published by AMA and AMA's statement in its brief at face value, 39% of AMA's member treating physicians do misrepresent, more than rarely, their patients' symptoms, diagnosis and severity of illness

---

[5] Petitioner cited this statistical survey in its opening brief. [Pet. Br. on the Merits, p. 30]

on insurance claims, and of the remaining 61%, some of them only do it rarely. AMA's argument is astounding. If the American Bar Association announced that 39% of lawyers in the United States were falsifying insurance claims, there would be a national criminal investigation of attorneys. If the American Management Association announced that 39% of corporate executives were filing false insurance claims, a hue and cry would echo through the halls of Congress. However, when 39% of treating physicians misrepresent their patient's medical condition on insurance benefits claims, the AMA cites those statistics as proof there should be a rebuttable presumption that treating physicians' opinions are correct. It is inconceivable that this Court would validate a presumption in favor of treating physicians' opinions when the treating physicians' own professional organization argues to this Court that 39% of its treating physicians, more than rarely, misrepresent their patients' symptoms, diagnosis and severity of illness in insurance benefits claims.

VII. THERE IS NO VIABLE REASON FOR A SPLIT STANDARD OF REVIEW FOR ERISA PLAN ADMINISTRATORS' DISABILITY DETERMINATIONS

The Ninth Circuit reviews the decisions of ERISA plan administrators using a split standard of review, a deferential standard for treating physician's opinions and an abuse of discretion standard for all other decisions. In reviewing plan administrator determinations regarding treating physician opinions, the Ninth Circuit grants deference and special weight to the opinions of treating physicians by requiring the plan administrator to rebut the opinions of treating physicians by specific legitimate reasons supported by substantial evidence. *Regula*, 266 F.3d at 1139. However, where the plan administrator has

been granted discretion by the plan, the Ninth Circuit applies an abuse of discretion standard of review to all other plan administrator decisions. *Atwood v. Newmont Gold Co. Inc.*, 45 F.3d 1317, 1322 (9th Cir. 1995).

Under the Ninth Circuit's split standard of review, a plan administrator may, among other things, weigh the opinions of non-treating physicians, weigh the credibility of statements by the claimant, weigh evidence from witnesses, interpret plan language and determine plan coverage, subject only to an abuse of discretion standard. However, when the plan administrator does not accept the opinion of a treating physician, she is required to give that opinion deference and special weight by rebutting the treating physician's opinion by specific, legitimate reasons supported by substantial evidence. *Regula*, 266 F.3d at 1139, 1144.

There is no logical or legal reason for this split standard of review. The Ninth Circuit's treating physician rule is based on a groundless distrust of plan administrators using their discretion to make ability-to-work determinations which are required by the plan. The rule is based upon sheer speculation that company manager-plan administrators will cheat their co-beneficiaries in the plan. There is no empirical evidence which supports such speculation. Either plan administrators can be trusted as prudent fiduciaries or they can not be trusted at all.

This Court in *Dickenson v. Zurko*, 527 U.S. 150, 154 (1999) recognized "the importance of maintaining a uniform approach to judicial review. . . ." While that case dealt with court review of the findings of an administrative agency, its reasoning is equally applicable to court/administrator review. There is no reason why the standard of review of ERISA plan administrator decisions regarding treating

physician opinions should be different from the standard of review for all other plan administrator decisions.

VIII. CONCLUSION

For the above reasons, this Court should reverse the holding of the Ninth Circuit Court of Appeals that its treating physician rule can be used (1) to show an actual conflict of interest that tainted Petitioner's decision to deny benefits, and therefore, requires *de novo* review of Petitioner's decision, and (2) as a test to determine the reasonableness of the plan administrator's decision. This Court should overturn the reversal of the Order on Summary Judgment and overturn the *sua sponte* order granting judgment to Respondent and remand the case to the Ninth Circuit with direction to review the Plan Manager's denial of benefits for abuse of discretion consistent with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*.

Respectfully submitted,

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STEDMAN'S
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Dictionary
26th Edition

[page 1484]

* * *

ra·dic·u·lop·a·thy (ra-dik'yu-lop'a-the). Disorder of the spinal nerve roots. SYN radiculitis. [radiculo- + G. *pathos*, suffering] **diabetic thoracic r.**, a type of diabetic neuropathy that affects primarily elderly patients with diabetes mellitus; clinically characterized by thoracic or abdominal pain, mainly anterior, but sometimes with radiation around the trunk from the midline; usually unilateral; may extend over several segments; probably due to ischemic injury of two or more contiguous roots; one type of diabetic polyradiculopathy.

* * *

FEB 24 2003

No. 02-469

In the Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN, PETITIONER

v.

KENNETH L. NORD

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether the administrator of an ERISA-covered disability plan must follow a "treating physician rule" in determining a participant's disability, so that the administrator is required to accept a treating physician's opinion on disability unless the administrator rebuts that opinion in writing based upon substantial evidence in the record.

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In the Supreme Court of the United States

No. 02-469

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v.

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TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF THE UNITED STATES

This case presents the question whether the administrator of a disability plan covered by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, is required, when deciding whether a claimant is disabled, to give special weight to the opinion of the claimant's treating physician. The Secretary of Labor has primary authority for the enforcement and interpretation of Title I of ERISA, and in that connection has issued regulations governing the procedures to be followed by plans in the processing of claims for benefits. 29 C.F.R. 2560.503-1.

STATEMENT

1. Petitioner Black & Decker Disability Plan (the plan) is an ERISA-governed employee welfare benefit plan that provides disability benefits to employees of Black and Decker Corporation (Black & Decker) and certain of its subsidiaries. Pet. App. 2-3. Black & Decker is the funding source for the plan and acts as plan administrator, although it has dele-

gated the authority to make initial determinations on claims to a third-party administrator, Metropolitan Life Insurance Company (MetLife). *Id.* at 3-6, 8-9. The plan provides benefits for eligible employees with a "disability," which the plan defines as "the complete inability * * * of a Participant to engage in his regular occupation with the Employer (during the first 30 months of Disability)." *Id.* at 3 n.2. The plan thereafter grants benefits if the employee has a "complete inability * * * to engage in any gainful occupation or employment * * * for which the Employee is * * * reasonably qualified by education, training, or experience." *Ibid.* The plan provides that a disability determination "shall be made by the Plan Manager based on suitable medical evidence and a review of the Participant's employment history that the Plan Manager deems satisfactory in its sole and absolute discretion." *Id.* at 3 n.1.

Respondent filed a claim in July 1997 for disability benefits under the plan. During the plan's consideration of his claim, respondent submitted reports from physicians who treated him beginning in March 1997, stating that he suffered from degenerative disc disease and was unable to perform certain functions required in his regular job as a material planner. Pet. App. 2-4; *id.* at 19-23 (describing respondent's course of treatment). MetLife denied the claim, and respondent sought review of that ruling. *Id.* at 5.

During the review process, petitioner referred respondent to a neurologist, Dr. Mitri, who examined respondent and concluded that, although he was suffering from disc disease, he was capable of performing a sedentary job. Pet. App. 5, 23-24. In addition, at the request of respondent's counsel, a Black & Decker human resources representative completed a work capacity evaluation form in which she gave an affirmative answer to the question whether, assuming that respondent faced chronic myofascial pain that would interfere with necessary interpersonal communications and his

ability to react appropriately to stress, respondent lacked the capacity to perform his job. *Id.* at 5, 34 n.2. MetLife thereafter made a final recommendation to the plan manager to deny the claim. *Id.* at 5.

On October 27, 1998, an employee in Black & Decker's Corporate Benefits department wrote respondent's counsel informing him that petitioner was upholding the denial of benefits. Pet. App. 5-6. The letter stated that "[w]e have thoroughly reviewed all the medical and vocational information in our possession." C.A. Supp. E.R. 166. The letter summarized the conclusions of respondent's treating physicians regarding his limitations; the results of x-rays, MRIs, and other diagnostic tests; and the opinion of Dr. Mitri based on his review of the tests and his independent examination of respondent. The letter also recounted that Dr. Mitri's report had been forwarded to respondent's counsel with a request to provide the comments of his treating physicians, but that respondent had provided no new or different information that would change the original decision. Finally, the letter explained that the work capacity evaluation completed by Black & Decker's human resource representative was insufficient to reverse the decision that respondent was not disabled. The letter concluded: "Based on our review, the medical evaluation supports [respondent's] ability to return to work at his own occupation, and therefore, he cannot be considered disabled as defined by the Black & Decker Disability Plan." *Id.* at 167.

2. Respondent then filed this action in federal district court under Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B), seeking to recover benefits under the plan. On the parties' cross-motions for summary judgment, the court granted judgment in favor of the plan. Pet. App. 18-36.

In addressing the applicable standard of judicial review, the district court noted that the plan gives its administrator discretion to determine benefits eligibility and that the

administrator's decision to deny benefits therefore would ordinarily be reviewed for abuse of discretion in accordance with *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 111-112 (1989). In addition, the court concluded that respondent had not adduced sufficient evidence that the conflict of interest resulting from the fact that Black & Decker both funds the plan and decides benefits claims under it had actually led to a breach of fiduciary duty that would warrant de novo rather than abuse-of-discretion review under Ninth Circuit precedent. Pet. App. 30-32. Under the latter test, the court observed, "[i]t is an abuse of discretion for an ERISA plan administrator to make a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Id.* at 32 (quoting *Atwood* v. *Newmont Gold Co.*, 45 F.3d 1317, 1323-1324 (9th Cir. 1995)). The court found no such error by the plan administrator. *Id.* at 31-32.

The district court reasoned that the administrator's finding of no disability was not improper simply because it was contradicted by some evidence in the record. Pet. App. 33. Consequently, the court explained, the opinion of Black & Decker's human resources representative, who lacked expertise in medicine or vocational evaluation, did not suffice to overturn the administrator's conclusion that respondent was not disabled, given the other evidence in the record before the administrator. *Id.* at 33-34. The court further concluded that the plan administrator was not required to credit the opinion of respondent's treating physicians over the opinion of an independent medical examiner, especially since petitioner gave respondent's treating physicians an opportunity to comment on the independent examiner's opinion and respondent apparently never took advantage of that opportunity. *Id.* at 34-35.

3. The court of appeals reversed. Pet. App. 1-16. It first explained that, where a plan clearly confers discretion on the

plan administrator to determine eligibility, an administrator like Black & Decker, which also acts as funding source for the plan, has an "inherent conflict of interest" that warrants review that is "still for abuse of discretion, [but it] is less deferential." *Id.* at 8 (quoting *Tremain* v. *Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999)). The court further explained, however, that, if the plan beneficiary provides "material, probative evidence" that the administrator's self-interest actually caused a breach of the administrator's fiduciary obligations to the beneficiary, then the court applies a de novo standard of review, unless the plan in rebuttal produces evidence to show that the conflict did not affect the decision to deny benefits. *Id.* at 9-10.

Applying that framework, the court of appeals concluded (Pet. App. 10) that its decision was "controlled" by its earlier decision of *Regula* v. *Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), petition for cert. pending, No. 01-1840. Pet. App. 10-12. In *Regula*, a divided panel held that a "treating physician rule" used in making and reviewing disability determinations under the Social Security Act, 42 U.S.C. 301 *et seq.*, also applies to disability determinations under benefit plans governed by ERISA. 266 F.3d at 1138-1144. As described by the court in *Regula*, the treating physician rule requires a plan administrator "who rejects [the treating physician's] opinions to come forward with specific reasons for his decision, based on substantial evidence in the record." *Id.* at 1139. The court in *Regula* also held that where a plan administrator also funds the plan, the administrator's deviation from the treating physician rule may furnish a basis for concluding that the apparent conflict of interest that results from the administrator's dual status had ripened into an "actual, serious conflict," thereby triggering de novo review of the benefit denial. *Id.* at 1147. In this case, the court of appeals found no reasons in the record "as to why the treating physicians' opinions were

unreliable and Dr. Mitri's more reliable." Pet. App. 13. It therefore concluded that petitioner's lack of explanation sufficed to show that it breached its fiduciary duty due to a conflict of interest, which in turn warranted the court's exercise of de novo review. *Id.* at 14-15.[1]

Applying a de novo standard, the court of appeals concluded that the only evidence contradicting respondent's claim of disability—Dr. Mitri's opinion—could not reasonably overcome all the other evidence that it regarded as establishing disability. Pet. App. 15. In the court's view, "no reasonable trier of fact could conclude that [respondent] is not disabled," and it therefore held that he is entitled to benefits under the plan for his first 30 months of disability. *Id.* at 15-16.

SUMMARY OF ARGUMENT

A. Nothing in ERISA or the Secretary of Labor's regulations mandates that a plan administrator give special weight to the opinions of a claimant's treating physician when rendering a benefits determination. Rather, the Act and regulations require plans to have procedures that provide for the "full and fair review" of claims and to provide participants with the "specific reasons" for any decision denying benefits. 29 U.S.C. 1133(1) and (2); 29 C.F.R. 2560.503-1. Those provisions do not purport to cabin a plan administrator's discretion in weighing conflicting medical evidence in determining a claimant's entitlement to benefits under the terms of a welfare benefits plan.

In the absence of a regulation requiring a treating physician rule, courts should not impose such a rule under their authority to fashion a "federal common law" under ERISA.

[1] The court of appeals also concluded that the plan administrator's rejection of the view of Black & Decker's human resources representative that claimant could not perform his past work was "some evidence" of a conflict of interest. Pet. App. 11.

Firestone, 489 U.S. at 110. Such a rule would unduly interfere with the ability of employers to establish and design plans that confer on plan administrators the discretion to weigh conflicting evidence. Moreover, a treating physician rule is not necessary to guard against arbitrary decision-making by plan administrators, as courts may review plan administrators' decisions to determine whether the administrator acted unreasonably in disregarding evidence of a claimant's disability, including the opinions of treating physicians. Courts also may review plan administrators' actions to determine whether they comply with the statutory and regulatory requirements of full and fair review and of providing specific reasons for a denial of benefits.

B. Nor does the special treating physician rule applicable under the Social Security disability program furnish a basis for judicial imposition of a similar rule under ERISA. That rule was adopted by the Commissioner of Social Security in regulations issued in 1991, to bring nationwide uniformity to a vast statutory benefits program and in light of varying court of appeals decisions addressing the question. ERISA, by contrast, governs a broad range of private benefit plans to which both the statute and implementing regulations issued by the Secretary of Labor permit significant flexibility in the processing of claims. Moreover, the Social Security Act's treating physician rule has not been uniformly or generally applied even under *statutory* disability programs other than Social Security.

ARGUMENT

A "TREATING PHYSICIAN RULE" SHOULD NOT BE APPLIED BY COURTS IN REVIEWING DISABILITY DETERMINATIONS UNDER PLANS COVERED BY ERISA

The Ninth Circuit, following its earlier decision in *Regula*, held that the "treating physician rule" applicable to Social

Security disability determinations governs a plan administrator's disability determination under employee benefits plans covered by ERISA. The Ninth Circuit stated in *Regula* that "[t]he treating physician rule applied in the Social Security setting requires that the administrative law judge ('ALJ') determining the claimant's eligibility for benefits give deference to the opinions of the claimant's treating physician, because 'he is employed to cure and has a greater opportunity to know and observe the patient as an individual.'" 266 F.3d at 1139 (quoting *Morgan* v. *Commissioner of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999)). "This grant of deference," the Ninth Circuit reasoned, "increases the accuracy of disability determinations by forcing the ALJ who rejects those opinions to come forward with specific reasons for his decision, based on substantial evidence in the record." *Ibid.* Based on what it regarded as "common sense" as well as an interest in "consistency in [judicial] review of disability determinations where benefits are protected by federal law," the Ninth Circuit saw "no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions." *Ibid.* That analysis was erroneous.

A. A Treating Physician Rule Is Inappropriate And Unnecessary Under ERISA

1. ERISA is a comprehensive statute designed "to promote the interests of employees and their beneficiaries in employee benefit plans," and "to protect contractually defined benefits." *Firestone*, 489 U.S. at 113 (internal quotation marks and citation omitted). The statute "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits," but rather protects their interests by, among other things, setting standards of reporting, disclosure, and fiduciary responsibility for plan administrators, and by providing a comprehensive civil enforcement scheme. *New*

York State Conference of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 514 U.S. 645, 651 (1995); accord *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983).

ERISA also requires certain plan procedures for the internal resolution of claims. ERISA requires that, "[i]n accordance with regulations of the Secretary, every employee benefit plan shall * * * provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. 1133(1). ERISA further requires that, again "[i]n accordance with regulations of the Secretary," plans must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. 1133(2). Congress's purpose in enacting those provisions was to "promot[e] internal resolution of claims and encourag[e] informal and non-adversarial proceedings under ERISA." *Bernstein* v. *CapitalCare, Inc.*, 70 F.3d 783, 788-789 (4th Cir. 1995); accord *Lindemann* v. *Mobil Oil Corp.*, 79 F.3d 647, 650 (7th Cir. 1996); *Grossmuller* v. *International Union, United Auto Workers, Local 813*, 715 F.2d 853, 857 (3d Cir. 1983).

Consistent with these principles, the Secretary of Labor has issued regulations that govern the consideration and determination of a claim for benefits under a plan. 29 C.F.R. 2560.503-1. Revisions to those regulations were issued in November 2000, 65 Fed. Reg. 70,246, and became effective for claims filed on or after January 1, 2002. 29 C.F.R. 2560-503-1(o).[2] The regulations have at all times required every

[2] Because respondent sought benefits under the plan before the effective date of the new regulations, the Department's prior regulation, 29 C.F.R. 2560.503-1 (2000), applies in this case.

benefit plan to establish and maintain a procedure "under which there will be a full and fair review of the claim." 29 C.F.R. 2560.503-1(h)(1); accord 29 C.F.R. 2560.503-1(g)(1) (2000). The new regulations further specify that a plan's claims procedures must "[p]rovide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim." 29 C.F.R. 2560.503-1(h)(2)(iv). In addition, the new regulations require group health and disability plans to provide that, "in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment," the administrator "shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment." 29 C.F.R. 2560.503-1(h)(3)(iii) and (4); see also Pension and Welfare Benefits Admin. (PWBA), Dep't of Labor, *Benefits Claims Procedure Regulation*, Question D-8 (Sept. 4, 2002) <http://www.dol.gov/ebsa/FAQs/faq_claims_proc_reg. html> (*reprinted in* Pet. App. 77) ("In all cases, a fiduciary must take appropriate steps to resolve the appeal in a prudent manner, including acquiring necessary information and advice, weighing the advice and information so obtained, and making an independent decision on the appeal.").

The regulations have at all times required that a plan administrator's final decision provide, in a manner calculated to be understood by the claimant, the "specific reason or reasons for the adverse determination" as well as specific references to the plan provisions on which the denial is based. 29 C.F.R. 2560.503-1(j)(1) and (2); 29 C.F.R. 2560.503-1(h)(3) (2000); accord 29 C.F.R. 2560.503-1(g)(1)(i) and (ii) (parallel requirements for initial decision on claim); 29 C.F.R. 2560.503-1(f)(1) and (2) (2000) (same). The new regulations additionally require, for certain determinations by group health plans and plans providing disability benefits, that the notice include either an "explanation of the scientific or

clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances," or a statement that such explanation will be provided on request. 29 C.F.R. 2560.503-1(j)(5)(ii); 29 C.F.R. 2560.503-1(g)(1)(v)(B).

Nothing in those regulatory provisions suggests that plan administrators must accord special deference to the opinions of treating physicians in considering a participant's entitlement to benefits under the plan or must explain why no such deference was given. Indeed, "[t]he [D]epartment did not intend to prescribe any particular process or safeguard to ensure and verify consistent decision making by plans. To the contrary, the [D]epartment intended to preserve the greatest flexibility possible for * * * operating claims processing systems consistent with the prudent administration of a plan." PWBA, Dep't of Labor, *Benefits Claims Procedure Regulation*, Question B-4 (*reprinted in* Pet. App. 52). The regulations thus reflect the Department's considered view that an informal and flexible system of claims processing best "reconcile[s] the need for procedural protections with the purely voluntary nature of the system through which these vital benefits are delivered." 65 Fed. Reg. at 70,246.

2. The absence of any requirement in ERISA itself or in the Secretary's implementing regulations that plan administrators accord special weight to opinions of treating physicians counsels strongly against courts adopting such a requirement on their own. Although courts have authority "to develop a 'federal common law of rights and obligations under ERISA-regulated plans,'" *Firestone*, 489 U.S. at 110 (quoting *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 56 (1987)), they should be particularly cautious in invoking that authority to impose special rules governing a particular subject matter when Congress has committed that subject matter (here, the review of benefit claims) to the primary jurisdiction of the Secretary, and the Secretary in turn has

imposed certain specific requirements but otherwise intentionally preserved broad flexibility for employers and others who design these private benefits plans and process claims under them. Compare *City of Milwaukee* v. *Illinois*, 451 U.S. 304 (1981); cf. *Geier* v. *American Honda Motor Co.*, 529 U.S. 861, 874-875, 881- 884 (2000).

More broadly, "[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Hughes Aircraft Co.* v. *Jacobson*, 525 U.S. 432, 443 (1999) (quoting *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890 (1996)); accord *Inter-Modal Rail Employees Ass'n* v. *Atchison, Topeka & Santa Fe Ry.*, 520 U.S. 510, 515 (1997); *Curtis-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995). Accordingly, quite aside from the Secretary's claims processing regulations that apply in this particular context, ERISA generally leaves to the employer decisions "regarding the form or structure of the Plan such as who is entitled to receive Plan benefits and in what amounts, or how such benefits are calculated." *Hughes Aircraft Co.*, 525 U.S. at 444. It follows that, in fashioning federal common law under ERISA, "courts may have to take account of competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996).

To be sure, once an employer establishes a plan covered by ERISA, plan administrators are fiduciaries, 29 U.S.C. 1002(21)(A), and must administer the plan consistent with their duties of prudence and loyalty. 29 U.S.C. 1104(a). But nothing in the common law of trusts requires plan administrators, in making factual determinations, to give special weight or deferential consideration to particular evidence

submitted by a beneficiary who seeks benefits under the plan. To the contrary, under ERISA the administrator's fiduciary duty runs to the plan as a whole, and the fiduciary's duty is to follow the terms of the plan and render correct decisions under it, carefully weighing all of the relevant evidence. 29 U.S.C. 1104(a)(1)(D); *Varity Corp.*, 516 U.S. at 513-514. Indeed, any rule requiring the fiduciary always to give special weight to the opinion of a beneficiary's treating physician would run counter to the background rule—which should not be displaced in the absence of strong reasons—that a finder of fact "should consider all the evidence, giving it whatever weight and credence it deserves." *United Postal Serv. Bd. of Governors* v. *Aikens*, 460 U.S. 711, 714 n.3 (1983); accord *Reeves* v. *Sanderson Plumbing Prods., Inc.*, 520 U.S. 133, 150 (2000) (factfinder's function includes "[c]redibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts.") (quoting *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986)); cf. *Tennant* v. *Peoria & Pekin Union Ry.*, 321 U.S. 29, 35 (1944) ("The very essence of [the jury's] function is to select from among conflicting inferences and conclusions that which it considers most reasonable.").

It is significant as well that employers are free under ERISA to design plans that grant discretion to the plan administrator to interpret plan terms and make eligibility determinations consistent with the administrator's fiduciary duties and the Act. *Firestone*, 489 U.S. at 111-115. A plan that confers discretion on the administrator to determine whether a claimant is disabled necessarily leaves to the administrator the discretion to resolve factual disputes, such as the nature and extent of the claimant's medical condition and physical limitations. In such instances, the administrator's determinations are reviewed deferentially by a court, *ibid.*, and are not subject to reversal "except to prevent an abuse * * * of * * * discretion." Restatement (Second) of

Trusts § 187 (1959) (cited with approval in *Firestone*, 489 U.S. at 111). Accordingly, in reviewing a plan administrator's decision that a participant is not disabled, "[t]he essential inquiry" for a court is whether the administrator "reasonably construe[d] and appl[ied] the * * * Plan in [the claimant's] case." *Block* v. *Pitney Bowes Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992) (R.B. Ginsburg, J.); accord *Leahy* v. *Raytheon Co.*, 315 F.3d 11, 17 (1st Cir. 2002) (an arbitrary and capricious standard "asks only whether a factfinder's decision is plausible in light of the record as a whole, * * * or, put another way, whether the decision is supported by substantial evidence in the record" (citations omitted)); Restatement (Second) of Trusts § 187, cmt. i, illus. 9 (1959) (trustee's decision on whether beneficiary is competent must be upheld "[i]f * * * reasonable men might differ on the question").[3]

Where an employer designs a plan that gives the plan administrator discretionary authority to weigh conflicting evidence, "[a] rule that requires plan administrators to consider certain types of evidence and to weigh that evidence in

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[3] As then-Judge Ginsburg explained in *Block*:

> The distinction, if any, between "arbitrary and capricious review" and review for "abuse of discretion" is subtle. *Cf. Ass'n of Data Processing Service Organizations, Inc.* v. *Board of Governors of Federal Reserve System*, 745 F.2d 677, 684 (D.C. Cir. 1984) (Scalia, J.) (distinction between substantial evidence test and arbitrary or capricious test is "'largely semantic'") (citations omitted). In the matter at hand, we are satisfied, there is no need to adopt one phrase and avoid the other. The reasonableness of the Plan Committee's decision is our polestar, as commentary relating to Administrative Procedure Act analogs almost uniformly affirms.

952 F.2d at 1454; accord; *Leahy* v. *Raytheon Co.*, 315 F.2d at 15 n.3; *Jebian* v. *Hewlett Packard Co. Employee Benefits Org. Income Protection Plan*, 310 F.3d 1173, 1177 (9th Cir. 2002); *Meditrust Fin. Servs. Corp.* v. *Sterling Chems., Inc.*, 168 F.3d 211, 214 (5th Cir. 1989); *Anderson* v. *Blue Cross/Blue Shield*, 907 F.2d 1072, 1075 n.2 (11th Cir. 1990).

a compulsory manner would effectively undermine that discretion." *Regula*, 266 F.3d at 1151 (Brunetti, J., dissenting). Likewise, if a review of the administrator's decision reveals that the administrator reasonably declined to defer to the opinion of a treating physician, the decision is not arbitrary simply because the decision failed to rebut the opinion with "specific, legitimate reasons." Pet. App. 13. For instance, the treating physician's opinion on its face may reveal why the administrator reasonably gave it little or no weight—*e.g.*, the opinion may not be accompanied or supported by objective or clinical findings, or the physician may have lacked relevant expertise. Cf. *id.* at 11 (rejecting respondent's contention that the administrator should have provided "specific reasons" for rejecting the opinion of petitioner's human resource representative, because the administrator "was under no duty to rebut with specificity all evidence adduced by [respondent] to support his claim"). Likewise, the reasons that an administrator did not rely on the treating physician's opinion may reasonably be apparent from other medical evidence, laboratory tests, or examinations, as well as non-medical evidence, that rebut the opinion of the treating physician regarding the claimant's condition or limitations.

3. The absence of a rule under ERISA that special weight be given to the opinion of the beneficiary's treating physician does not mean that plan administrators may arbitrarily disregard such opinions—or, for that matter, that they may disregard any other reliable evidence that bears on an entitlement to benefits under the plan. If a plan denies a claim for benefits, the beneficiary may challenge that action under 29 U.S.C. 1132(a)(1)(B). Even under a deferential standard of review, a court may determine in a particular case that the decision-maker's disregard of the opinion of the claimant's treating physician (or other material evidence) constituted an abuse of discretion. Cf. *Connors* v. *Connecti-*

cut Gen. Life Ins. Co., 272 F.3d 127, 135-136 (2d Cir. 2001) (district court, on de novo review of administrator's decision, clearly erred in rejecting treating physician's opinion because district court erroneously believed that participant had been referred to physician by his attorney when physician, in fact, had been participant's treating physician for several years).

The Act and regulations provide other significant protections for plan participants and beneficiaries as well. As discussed above, plan procedures must provide for a "full and fair review" of a denial of a claim for benefits (29 U.S.C. 1133(2); 29 C.F.R. 2560.503-1(h)(1)), and such a review must "take[] into account all comments, documents, records, and other information submitted by the claimant relating to the claim" (29 C.F.R. 2560.503-1(h)(2)(iv)). The plan administrator's decision must also provide the "specific reasons" for any adverse determination (29 U.S.C. 1133(1); 29 C.F.R. 2560.503-1(g)(1)(i) and (j)(1)), and the beneficiary must be furnished, or afforded the right to obtain, an "explanation of the scientific or clinical judgment" for certain determinations by group health and disability plans (29 C.F.R. 2560.503-1(j)(5)(ii)).

Under those provisions, "the persistent core requirements of review intended to be full and fair include knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision." *Grossmuller*, 715 F.2d at 858 n.5. The purpose of requiring specific reasons for an administrator's denial of benefits is "to afford the beneficiary and the courts a sufficiently precise understanding of the ground for the denial to permit a realistic possibility of review, even under a deferential standard." *Halpin* v. *W.W. Grainger, Inc.*, 962 F.2d 685, 694 (7th Cir. 1992). Thus, in an appropriate case, a

plan administrator's failure to adequately address the well-reasoned and documented opinion of a physician may violate ERISA and the Secretary's regulations. *E.g.*, *Hackett* v. *Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771, 774-775 & n.3 (7th Cir. 2003) (reversing administrator's decision for failing to provide adequate reasons for terminating disability benefits that plan had been paying for twelve years, where termination was based on one physician's opinion that failed to provide "[a]ny non-arbitrary explanation" why his opinion differed from that of several previous doctors).[4] Finally, where, as here, the plan administrator both funds the plan and renders decisions on claims for benefits under it, more searching scrutiny of the administrator's denial of a claim is warranted. *Firestone*, 489 U.S. at 115; p. 27, *infra*. In those circumstances, there may be special justification for expecting the administrator to explain his consideration of material evidence submitted by the claimant.

4. The above principles also counsel against adoption of a special "treating physician rule" even where a plan, in the exceptional case after *Firestone*, does not confer discretion on the plan administrator to resolve factual questions and the district court's review of the administrator's decision

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[4] Respondent did not argue in his briefs in the court of appeals, or in his brief in opposition to the certiorari petition, that the plan administrator's decision in this case failed to comply with 29 U.S.C. 1133 or the Department's regulations because of any inadequacies in its explanation concerning the opinions of treating physicians. Compare Pet. App. 11-12 n.7 (rejecting contention that administrator was required to provide "specific reasons for rejecting the opinion" of petitioner's human resource representative). Respondent relied only on the judge-made treating physician rule. For that reason, and because new regulations are now in effect, this brief does not address whether the administrator's decision satisfied 29 U.S.C. 1133 and the regulations that applied at the time.

therefore is de novo under *Firestone*, 489 U.S. at 111-115.[5] In that situation, the district court is charged with interpreting the relevant terms of the plan and determining the claimant's entitlement to benefits, typically based on the record before the administrator.[6] The district court thus performs essentially the same function as the plan administrator, weighing the reports of the physicians who have treated or examined the claimant or reviewed his records, as well as any other relevant evidence in the record. Compare *Richardson* v. *Perales*, 402 U.S. 389 (1971) (upholding Social Security hearing examiner's reliance on written medical reports, without requiring physicians to testify). In the absence of any plan term that requires deference to the opinion of a treating physician, the district court would not be automatically required to give special weight to such an opinion.

On appeal of a district court's decision in such a case, any factual findings by the district court presumably must be upheld under Federal Rule of Civil Procedure 52(a) unless they are clearly erroneous, *i.e.* "the reviewing court on the

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[5] The courts of appeals generally agree that in such circumstances the administrator's factual findings are reviewed de novo. *Riedl* v. *General Am. Life Ins. Co.*, 248 F.3d 753, 756 (8th Cir. 2001); *Kinstler* v. *First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 249-251 (2d Cir. 1999); *Walker* v. *American Home Shield Long Term Disability Plan*, 180 F.3d 1065, 1069 (9th Cir. 1999); *Rowan* v. *Unum Life Ins. Co.*, 119 F.3d 433, 435 (6th Cir. 1997); *Ramsey* v. *Hercules, Inc.*, 77 F.3d 199, 203-205 (7th Cir. 1996); *Luby* v. *Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991); *Reinking* v. *Philadelphia Am. Life Ins. Co.*, 910 F.2d 1210, 1213-1214 (4th Cir. 1990), overruled on other grounds by *Quesinberry* v. *Life Ins. Co. of N. Am.*, 987 F.2d 1017 (4th Cir. 1993); but see *Pierre* v. *Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552, 1557-1562 (5th Cir.), cert. denied, 502 U.S. 973 (1991).

[6] *Hall* v. *Unum Life Ins.*, 300 F.3d 1197, 1202 (10th Cir. 2002); *Doe* v. *Travelers Ins. Co.*, 167 F.3d 53, 57-58 (1st Cir. 1999); *DeFelice* v. *American Int'l Life Assurance Co.*, 112 F.3d 61, 65 (2d Cir. 1997).

entire evidence is left with the definite and firm conviction that a mistake has been committed." *United States* v. *United States Gypsum Co.*, 333 U.S. 364, 395 (1948); cf. *Dickinson* v. *Zurko*, 527 U.S. 150, 153, 162-163 (1999) (observing that the clearly erroneous standard "has been considered somewhat stricter (*i.e.* allowing somewhat closer judicial review)" than the substantial evidence standard under 5 U.S.C. 706, "[b]ut the difference is a subtle one"). Any requirement by the courts of appeals that district courts categorically give special weight to the opinions of treating sources, but not other opinion evidence, would interfere with the traditional discretion of trial courts to weigh conflicting medical evidence. *Anderson* v. *City of Bessemer*, 470 U.S. 564, 573 (1985); *Zenith Radio Corp.* v. *Hazeltine Research, Inc.*, 395 U.S. 100, 123 (1969). Similarly, while the district court's findings must "permit intelligent appellate review," reviewing courts do not require either "'punctilious detail'" or "'slavish tracing of the claims issue by issue and witness by witness.'" *Krieger* v. *Gold Bond Bldg. Prods.*, 863 F.2d 1091, 1097 (2d Cir. 1988) (quoting *Ratliff* v. *Governor's Highway Safety Program*, 791 F.2d 394, 400 (5th Cir. 1986)).

B. Application Of A Treating Physician Rule Under The Social Security Act Does Not Justify Judicial Imposition Of Such A Rule Under ERISA

The court of appeals held that the special treating physician rule applied under the Social Security disability program warranted the fashioning of a parallel rule by the courts to govern private benefit plans under ERISA. The court of appeals overlooked the special circumstances that gave rise to the rule applied in the Social Security program and critical distinctions between that program and ERISA.

1. The Commissioner of Social Security adopted a treating physician rule in regulations issued in 1991 in response to judicial decisions that had developed similar rules in the course of reviewing disability determinations by ALJs who

had considered such opinion evidence. Prior to 1991, most courts of appeals generally held that the ALJ should give special weight to the claimant's treating physician as the medical expert with best opportunity to familiarize himself with the claimant's condition, although "significant variation exist[ed] * * * with regard to the treatment to be afforded to the treating physician's opinion and the evidence required to refute it." James A. Maccaro, *The Treating Physician Rule and the Adjudication of Claims for Social Security Disability Benefits*, 41 Soc. Sec. Rep. Serv. (West) 833, 834 (1993).

As the Commissioner explained when the regulations were promulgated, the appellate precedents requiring that special weight be given to the opinions of treating physicians did not hold that such a rule was required by the Social Security Act. 56 Fed. Reg. 36,932, 36,934 (1991). Rather, those precedents developed in the course of case-by-case review of individual ALJ decisions under the substantial evidence test required by 42 U.S.C. 405(g). Two courts of appeals, moreover, had specifically rejected the principle that a treating physician's opinion was necessarily entitled to special weight under the Social Security Act. *Pagan* v. *Secretary of Health & Human Servs.*, 819 F.2d 1, 3-4 (1st Cir. 1987) (opinion of treating physician "not entitled to greater weight" over the opinion of "a consulting physician"; "[i]t is the [agency's] province to resolve conflicts in the medical evidence"); *Stephens* v. *Heckler*, 766 F.2d 284, 289 (7th Cir. 1985) ("Experience and knowledge * * * lie on the side of the treating physician, expertise and knowledge of similar cases on the side of the consulting specialist. How these weigh in a particular case is a question for the [agency], subject only to the rule that the final decision must be supported by 'substantial evidence.'").

In 1991, the Commissioner concluded "that judicial decisions in several circuits pointed to a need for a clear policy

statement that would encourage uniformity of adjudication and provide the public and the courts with a definitive explanation of [the Commissioner's] policy on weighing treating source opinions." 56 Fed. Reg. at 36,934; see also 52 Fed. Reg. 13,014, 13,016 (1987) (proposing the regulations "in response to certain Federal Circuit Court of Appeals decisions"). The Commissioner accordingly promulgated regulations to resolve the controversy and furnish "detailed provisions that would prescribe rules stating how [the Commissioner] would consider and weigh medical opinions," including those from the claimant's treating source. 56 Fed. Reg. at 36,934.

The regulations define a "[t]reating source" as an "acceptable medical source who * * * has, or has had, an ongoing treatment relationship" with the claimant, 20 C.F.R. 404.1502, and set forth the standards for evaluating opinions from that source under 20 C.F.R. 404.1527.[7] The regulations provide that, in "[e]valuating opinion evidence," the Commissioner "[g]enerally [will] give more weight to opinions from * * * treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations." 20 C.F.R. 404.1527(d)(2). The Commissioner explained in issuing the regulations that, "[a]ll things being equal, * * * [the Commissioner] will always give greater weight to the treating source's opinion than to the opinions of nontreating sources." 56 Fed. Reg. at 36,936.

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[7] The Commissioner has promulgated a similar regulation, 20 C.F.R. 416.927, to govern disability determinations for indigent persons under the Supplemental Security Income Program in Title XVI of the Social Security Act.

The Commissioner will give the treating source's opinion on the nature and severity of a claimant's impairments "controlling weight" if it "is well-supported by medically accepted clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the claimant's] case record." 20 C.F.R. 404.1527(d)(2). Where the opinion is not given controlling weight, the Commissioner will consider other factors, including the "[l]ength of the treatment relationship and the frequency of examination," "[s]upportability," "[c]onsistency," and "[s]pecialization" of the treating source, "in determining the weight to give to the opinion." 20 C.F.R. 404.1527(d)(2)(i), (d)(3)-(d)(5). "[E]ven if the treating source's opinion is not such that [the Commissioner] can give it controlling weight, [the Commissioner] will still give the opinion more weight than [she] would have given it if it came from a nontreating source." 56 Fed. Reg. at 36,936; accord *id.* at 36,936-36,937. The Commissioner's regulation further informs claimants that "[w]e will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion." 20 C.F.R. 404.1527(d)(2); 61 Fed. Reg. 34,490, 34,492 (1996) (Soc. Sec. Ruling 96-2p).

The Commissioner's regulations are binding upon courts reviewing the agency's final decision even where the regulations "differ from [a circuit's own prior] version of the treating physician rule in material respects." *Schisler* v. *Sullivan*, 3 F.3d 563, 566, 567, 568 (2d Cir. 1993) (noting that Commissioner's regulations supplanted circuit law by "accord[ing] less deference to unsupported treating physician's opinions," by considering "the length of the relationship between the treating source and the claimant," and by "permit[ting] the opinions of nonexamining sources to override treating sources' opinions, provided they are supported by evidence in the record").

2. The Ninth Circuit in *Regula* imported the Social Security Act's treating physician rule into the ERISA context based on what the court regarded as "common sense" and on an interest in "consistency in [judicial] review of disability determinations where benefits are protected by federal law." 266 F.3d at 1139. The court of appeals erred in equating the two situations. The Social Security Act is a nationwide statutory benefits program paid for by federal funds and subject to uniform administration by the Commissioner of Social Security. Moreover, while there is substantial reason to doubt that the courts of appeals in the 1980s had authority to impose on the Commissioner general standards concerning what weight must be given to treating physician opinions, that issue is now beside the point because the Commissioner in 1991 elected to adopt such a rule in regulations and those regulations now control the adjudication of claims under the program.

The Commissioner has often exercised her "exceptionally broad" authority under 42 U.S.C. 405(a), see *Heckler* v. *Campbell*, 461 U.S. 458, 466 (1983), to establish rules for the receipt and assessment of proof for benefit eligibility under the Act in order to achieve efficiency and uniformity to the processing of over 2.5 million claims for benefits, of which over 200,000 are considered by ALJs. *Cleveland* v. *Policy Mgmt. Sys. Corp.*, 526 U.S. 795, 803 (1999); *Schweiker* v. *Chilicky*, 487 U.S. 412, 424 (1988); *Bowen* v. *Yuckert*, 482 U.S. 137, 153 (1987); *Heckler* v. *Campbell*, 461 U.S. at 460-462. In similar fashion, the Commissioner reasonably determined, in the face of the many but varying court of appeals decisions on the subject, to adopt a treating physician rule that could be applied in a uniform way throughout the Nation. The adoption of regulations by the responsible Executive agency to bring nationwide uniformity to a massive statutory benefits program does not support judicial imposition of a treating physician rule on a broad range of

private and voluntary benefit plans where the responsible Executive agency has not done so and instead has sought to preserve maximum flexibility for the design of such plans and their processing of claims.

Indeed, the treating physician rule has not consistently been applied outside the Social Security context even under other *statutory* disability programs. In addition to the Social Security context, the rule, or some variation of it, has been adopted by some courts in two federal statutory settings. A few courts, in reviewing disability determinations by the Department of Labor's Benefits Review Board under the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 901 *et seq.*, have embraced a treating physician rule similar to the one developed under the Social Security Act. *Amos* v. *Director, OWCP*, 153 F.3d 1051, 1054 (9th Cir. 1998), cert. denied, 528 U.S. 809 (1999); *Pietrunti* v. *Director, OWCP*, 119 F.3d 1035, 1042 (2d Cir. 1997).

Additionally, courts reviewing decisions by the Benefits Review Board under the Black Lung Benefits Act (BLBA), 30 U.S.C. 901 *et seq.*, have adopted a less deferential version of a treating physician rule that permits, but does not require, hearing officers to defer to the opinions of treating physicians. *National Mining Ass'n* v. *Department of Labor*, 292 F.3d 849, 861 (D.C. Cir. 2002) (noting "consensus among [the] courts * * * that an agency adjudicator may give weight to the treating physician's opinion when doing so makes sense in light of the evidence and the record, but may not mechanistically credit the treating physician solely because of his relationship with the claimant."). In 2000, the Department of Labor adopted a regulation on the subject under the BLBA that "attempted to codify principles embodied in case law." 64 Fed. Reg. 54,966, 54,969 (1999).

That regulation permits (but does not require) the hearing officer to give "controlling weight" to a treating physician's opinion "in light of its reasoning and documentation, [and]

other relevant evidence and the record as a whole." 20 C.F.R. 718.104(d)(5); *National Mining Ass'n*, 292 F.3d at 861, 870-871 (upholding regulation and noting that it "codifies judicial precedent and does not work a substantive change in the law"). In issuing the regulation, the Department stated that it "is not an outcome-determinative evidentiary rule," because it permits the adjudicator to "consider[] the credibility of the physician's opinion in light of its documentation and reasoning and the relative merits of the other relevant medical evidence of record." 65 Fed. Reg. 79,920, 79,923 (2000). The Department also distinguished its regulation from the one governing Social Security claims, explaining that the Social Security rule "demonstrates an affirmative preference for reports from treating physicians." 65 Fed. Reg. at 79,934.

In two other federal statutory disability programs, courts have rejected a treating physician rule outright and the responsible federal agency has declined to adopt one. In *White* v. *Principi*, 243 F.3d 1378, 1381 (Fed. Cir. 2001), the court of appeals held that the Board of Veterans' Appeals need not accord special weight to treating physician opinions in determining entitlement to veterans' benefits for service-connected disabilities because nothing in the federal statute that permits the Board to consider evidence, 38 U.S.C. 7104(a), "suggest[s] that the VA should give more weight to a piece of evidence based solely on its source." Similarly, in *Dray* v. *Railroad Retirement Board*, 10 F.3d 1306 (7th Cir. 1993), the court rejected a treating physician rule for disability determinations under the Railroad Retirement Act of 1974, 45 U.S.C. 231 *et seq.*, reasoning that "[i]n the case of dueling doctors, it remains the province of the [finder of fact] to decide whom to believe—a treating doctor whose experience and knowledge about the case may (or may not) be relevant to understanding the claimant's condition, or a

consulting specialist who may bring expertise and knowledge about similar cases." *Dray*, 10 F.3d at 1311.

A majority of state courts likewise have rejected a treating physician rule under state worker's compensation statutes. *Conradt* v. *Mt. Carmel Sch.*, 539 N.W.2d 713, 717 (Wis. Ct. App. 1995) (noting majority rule and observing that "[a] handful of states allow trial courts to give greater deference to the testimony of an attending physician, yet without creating a presumption that this is so") (emphasis removed); see generally 8 Arthur Larson & Lex K. Larson, *Larson's Workers' Compensation Law* § 130.05D[4][b] (2002) (discussing state court decisions). Some courts rejecting a treating physician rule have reasoned that it would unduly interfere with discretion accorded the finder of fact to weigh conflicting medical opinions.[8] Other courts have questioned the wisdom of categorically deferring to the opinions of treating physicians.[9] For similar reasons, New York courts

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[8] *Doyle* v. *Public Employees' Retirement Sys.*, 808 So. 2d 902, 907 (Miss. 2002) ("The law contains no such duty of deference [to the treating physician], and * * * this Court cannot reweigh the facts."); *Dillon* v. *Whirlpool Corp.*, 19 P.3d 951, 953-954 (Or. Ct. App. 2001) ("[D]ivided medical opinion leaves the Board in the position of evaluating the evidence."); *Conradt*, 539 N.W.2d at 716 ("[I]t is for [the state commission] to decide if one expert's testimony is more persuasive than another's."); *Ashe* v. *Workmen's Comp. Appeal Bd.*, 648 A.2d 1306, 1308 (Pa. Commw. Ct. 1994) ("[T]he weighing of testimony is solely within the province of the referee, and his decision to accept testimony of one competent witness over another will not be disturbed on appeal."); *Gibson* v. *City of Lincoln*, 376 N.W.2d 785, 791 (Neb. 1985) (" 'trier of fact' remains the sole judge of a witness' credibility and the testimony's weight").

[9] *McClanahan* v. *Raley's Inc.*, 34 P.3d 573, 577 (Nev. 2001) ("We do not agree that because a physician has a duty to cure a patient that the physician will necessarily be more familiar with an issue."); *Gibson*, 376 N.W.2d at 791 ("Generally, an expert witness' firsthand knowledge is a factor which may affect such witness' credibility and weight given to the testimony from that expert, but presence or absence of firsthand knowledge does not, by itself, necessarily establish preference or priority in evidentiary value.").

have rejected the treating physician rule for disability determinations under the State's employee retirement system. *E.g.*, *Irish* v. *McCall*, 747 N.Y.S. 2d 610, 611 (App. Div. 2002) ("[W]e have adhered to the view that the Comptroller is vested with the authority to resolve conflicts in medical opinion and credit the testimony of one medical expert over another.").

These authorities demonstrate the absence of a generally accepted treating physician rule applicable to statutory disability determinations. The Ninth Circuit thus erred in concluding that a treating physician rule under ERISA is necessary to ensure uniformity of judicial decisions reviewing disability determinations—even assuming, arguendo, that it was the proper role of that court to bring uniformity to disparate statutory programs.

C. The Case Should Be Remanded For Further Proceedings In Which Special Weight Need Not Be Given To The Opinions Of Respondent's Treating Physicians

The Ninth Circuit held that Black & Decker's dual status as funding source and plan administrator created a conflict of interest (Pet. App. 8-9) and that the plan administrator's failure to apply a treating physician rule in those circumstances constituted a breach of fiduciary duty (*id.* at 8-14). The court of appeals further held that such a breach triggered a de novo standard of judicial review, and under that standard, no disputed issue of material fact existed as to whether respondent was disabled. *Id.* at 14-15. The United States agrees that the employer's dual role in funding the plan and deciding claims under it created a conflict of interest that triggered a requirement of more searching judicial review under *Firestone*, 489 U.S. at 115, and petitioner did not seek review of the court of appeals' ruling to that effect.

See also Pet. App. 31 (district court opinion) ("Defendant * * * concedes that there is an apparent or technical conflict of interest due to Black & Decker's dual role as insurer and administrator.").[10] Nor has petitioner challenged the court of appeals' further conclusion that, once a claimant provides material evidence that such a conflict of interest in turn actually affected the administrator's decision to deny benefits and thereby resulted in a breach of fiduciary duty, a de novo standard of review is appropriate unless the plan produces evidence that no such breach occurred. *Id.* at 9-15. Nonetheless, the Ninth Circuit's judgment should be set aside, for two reasons.

First, the court held that a de novo standard of review was required based in part on its erroneous view that ERISA plan administrators are required to follow the treating physician rule as set forth in *Regula*. Pet. App. 8-15. In particular, the court of appeals relied on the administrator's failure to follow that rule as evidence that petitioner's conflict of interest actually influenced the administrator's decision and constituted a breach of fiduciary duty. *Id.* at 9, 12, 14.

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[10] Under *Firestone*, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)). Courts have differed on whether a conflict of interest is present where the fiduciary both decides a claim for benefits and is responsible for paying the claim out of its own assets. Compare Pet. App. 8-9; *Yochum* v. *Barnett Banks, Inc. Severance Pay Plan*, 234 F.3d 541, 544 (11th Cir. 2000); *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377, 391-392 (3d Cir. 2000); *Peruzzi* v. *Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998); *Doe* v. *Group Hospitalization & Med. Servs.*, 3 F.3d 80, 86-87 (4th Cir. 1993), with *Bill Gray Enters., Inc. Employee Health & Welfare Plan* v. *Gourley*, 248 F.3d 206, 216-217 (3d Cir. 2001); *Kimber* v. *Thiokol Corp.*, 196 F.3d 1092, 1098 (10th Cir. 1999); *Davolt* v. *Executive Comm. of O'Reilly Auto.*, 206 F.3d 806, 809 (8th Cir. 2000).

Second, even if a de novo standard of review was appropriate in this case, the court of appeals erred in concluding that "[t]he administrative record reveals no genuine dispute as to whether [respondent] is disabled within the meaning of the plan." Pet. App. 15. As the court of appeals acknowledged, Dr. Mitri, a neurologist whom petitioner retained for an independent medical examination and evaluation, cf. 29 C.F.R. 2560.503-1(h)(3)(iii), opined that respondent "should be able to perform sedentary work, with no material limitations in his ability to sit, while taking pain reduction medication." Pet. App. 5. The judgment below should accordingly be reversed so that the Ninth Circuit, without regard to a treating physician rule, may reconsider the appropriate standard of review and determine whether, under that standard, to affirm the district court's decision or instead to reverse and remand for further proceedings.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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—v.—

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BRIEF OF DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN AND DELTA AIR LINES, INC. AMICI CURIAE IN SUPPORT OF PETITIONER THE BLACK & DECKER DISABILITY PLAN

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QUESTION PRESENTED

Whether the United States Court of Appeals for the Ninth Circuit erred in holding that the treating-physician rule must be applied in deciding claims for disability benefits under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*

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INTEREST OF THE AMICI CURIAE[1]

The Delta Family-Care Disability and Survivorship Plan (the "Plan") is a non-contributory employee welfare benefit plan, established and maintained pursuant to the

[1] Petitioner and Respondent have consented to the filing of this Brief. No counsel for a party authored this Brief in whole or in part. No persons or entities other than the *Amici Curiae* made a monetary contribution to the preparation or submission of this Brief.

Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. § 1001 *et seq.*[2] It is sponsored by Delta Air Lines, Inc. ("Delta"). The Plan provides short-term disability, long-term disability and survivorship benefits to over 80,000 non-pilot employees of Delta and their beneficiaries. The Plan has participants in almost every state and is currently subject to a split in the Circuits on the Question Presented. *Compare Regula v. Delta Family-Care Disability and Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001) (2 to 1 decision) (applying treating-physician rule to ERISA disability cases) *with Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002) (*per curiam*) (rejecting *Regula* and the treating-physician rule in ERISA disability cases) *and Marshall v. Delta Family-Care Disability and Survivorship Plan*, 258 F.3d 834, 842 (8th Cir. 2001) (same). The Plan is also the Petitioner in *Delta Family-Care Disability and Survivorship Plan v. Regula*, No. 01-1840 (June 13, 2002), which presents the same Question Presented as well as a second question.

STATEMENT OF THE CASE OF THE AMICI CURIAE

This Court has granted certiorari to the United States Court of Appeals for the Ninth Circuit to review that Court's decision in *Nord v. Black & Decker Disability Plan*, 296 F.3d 823 (9th Cir. 2002). In that case, a panel of the Ninth Circuit, in an opinion written by Judge Betty Fletcher, followed its prior decision in *Regula v. Delta Family-Care Disability and Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), also written by Judge

[2] The text of the brief will only cite to sections of ERISA as codified in the United States Code. Parallel citations to sections of ERISA are found in the Table of Authorities. *See supra* at v.

Fletcher, and applied the so-called "treating-physician rule" to a case involving an ERISA claim for long-term disability benefits under the Black & Decker Disability Plan.

Because the Court in *Nord* merely applied the treating-physician rule that it had created in *Regula*, *Nord*, 296 F.3d at 829, much of the analysis and reasoning behind its creation of that new ERISA rule is found in the *Regula* decision. The analysis in *Regula*, in turn, reflects various assumptions regarding the Plan that the Ninth Circuit majority made without any record evidence. Before explaining why the treating-physician rule should be inapplicable to ERISA disability cases and should be rejected by this Court, a description of the Plan's actual operation with respect to claims such as Frank Regula's, as opposed to the Ninth Circuit's unfounded assumptions, is necessary. This description reflects the experiences of the Plan's agents regarding the Plan's operation during the time period that Frank Regula's benefits were discontinued and he completed the exhaustion of administrative remedies (*i.e.*, the Plan Year ending June 30, 1996). The description is stated in general terms because there may be specific claims with respect to which the Plan acted differently based upon the unique facts of that particular claim.

1. The Plan provides short-term, long-term and survivorship benefits to participating non-pilot Delta employees. To receive short-term disability benefits, a participant must generally be unable to perform their own job at Delta. With exceptions not relevant here, short-term disability benefits last for a maximum of 26 weeks. After short-term disability benefits are exhausted, a participant may apply for long-term disability benefits. The standard for long-term disability is more rigorous. It requires a participant to be unable to perform any part-

time or full-time work of any type for any employer, including self-employment. This standard is markedly different than the Social Security Administration standard for the payment of disability benefits. *See infra* at 17-18.

2. The Plan is administered by the Administrative Committee of Delta Air Lines, Inc. ("Administrative Committee"). The Administrative Committee is the Plan's Named Fiduciary and is vested with the discretion to decide claims under the Plan. *See Regula*, 266 F.3d at 1144. The Administrative Committee is composed of Delta employees as authorized by ERISA. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 105 (1989).

The Administrative Committee is more familiar with terms and application of the Plan than any entity outside the Plan or any Court. In the year relevant to Regula's appeal to the Administrative Committee for the continuation of his benefits, the Administrative Committee heard 51 appeals regarding the denial or discontinuation of disability benefits under the Plan. Over 25 percent of the appealed decisions were reversed in favor of the Claimant.[3] This figure does not include other appeals decided in favor of claimants by the Administrative Subcommittee which provides the first level of review under the Plan.[4]

The Plan is funded by irrevocable contributions that Delta makes to a qualified trust based upon expected claims. The assets of the trust far exceeded the claims

[3] For comparison's sake, this is far greater than the 9.5% reversal rate of the federal Courts of Appeals. *See*, Administrative Office of the United States Courts, U.S. Courts of Appeals—Appeals Terminated on the Merits During the 12-Month Period Ending March 31, 2002. *www.uscourts.gov/caseload2002/tables/605mar02.pdf*.

[4] Only those appeals denied by the Administrative Subcommittee may be appealed to the Administrative Committee.

made under the Plan in the Plan year relevant to Regula's claim. In the Plan year ending June 30, 1996, the trust's assets were $350,315,163.00 against claims of $28,935,736.00. Thus, Delta had essentially pre-paid all of the claims made against the Plan (and then some) in those years with funds that could not revert to Delta. Delta did this even though neither ERISA, nor any other law, requires Delta to provide this funding through irrevocable contributions or otherwise. *See, e.g.*, 29 U.S.C. §§ 1081-86 (limiting ERISA's funding requirement to certain defined pension benefit plans).

After a claimant[5] is approved for the receipt of long-term disability benefits, the Plan provides that those benefits are continued upon its periodic receipt of additional, current information regarding the claimant's condition. At the time Regula's benefits were discontinued, this information was usually required to be provided every three to twelve months. *See, e.g., Regula*, 266 F.3d at 1134 (noting that Regula was required to submit updated information every three months).

Once a claimant begins to receive long-term disability benefits, there are generally only two occurrences that lead to a thorough re-examination of eligibility for disability benefits. The first is a report to the Plan from a third party that the claimant is actually working while receiving benefits or engaging in activities inconsistent with the claimed disability. As a result, despite the medical evidence submitted by the claimant's physician, these claimants may well be ineligible for benefits under the Plan depending upon the result of the Plan's subsequent investigation. The second circumstance that normally precedes a re-examination of a claimant's eligibility

[5] The term "claimant" as opposed to "participant" is used to distinguish a participant who has filed a claim from the other participants in the Plan.

is the claimant's own physician's indication that the claimant can perform some work or that claimant's condition is improving to a substantial degree.

In the first case, when there has been a report that a claimant is actually working or engaging in activities inconsistent with the claimed disability, the Plan will usually first ask the claimant's own physician for an update on claimant's condition and also schedule an examination with an independent medical expert. In the second case, where the claimant's own physician indicates that claimant is improving or may be able to return to work, depending on the Plan's evaluation of the information, the claimant's benefits may be immediately discontinued or the claimant may be sent to an independent evaluation for additional examination. The latter often occurs when the claimant's physician only opines that the claimant is unable to perform his own job as opposed to any occupation.

3. The Plan does not have as employees its own physicians for the purpose of performing medical examinations. Typically, the Administrative Committee uses a third-party service that provides references to physicians who have attained certain qualifications in the relevant specialty. On occasion, the Plan itself may directly select a physician if the Plan is aware that the physician is an expert in the relevant field and is otherwise suitable to examine the claimant. Ironically, of those independent medical examiners selected by the Plan, some are physicians who have treated other claimants and whose reports and analysis were seen as thorough, reasoned and well-founded by the Plan's agents, regardless of whether the physician thought that the claimant was disabled. Of those *qualified* physicians from whom the Plan received an opinion, the thoroughness of the opinion is the primary factor that leads the Plan to seek additional opinions from that physician in other claims.

The Ninth Circuit's decision in *Regula* begins its analysis from the simple misguided assumption: Claimant's physician good, independent physician bad. *See Regula*, 266 F.3d at 1139 & 1143. Given the Plan's processes, as described above, the Ninth Circuit's assumption was surprising and unsupported. The Ninth Circuit analysis also starts from another false, unsupported assumption—that Delta repeatedly sends its claimants to the same independent physicians because they routinely find claimants not disabled. *Id.* at 1144. Not only was this argument not advanced by Regula, but there is no record evidence for it and the Ninth Circuit provided no citation to the record or otherwise to validate this assumption.

It is true that, as in the *Regula* case, when there are orthopaedic injuries involved the Plan usually finds it more relevant to seek the opinion of an orthopaedist rather than some other type of medical professional such as a chiropractor, though the Plan accepts and analyzes each opinion on its own merits. This reasonable preference is also ignored by the Ninth Circuit's analysis. All told, there is no factual basis for the Ninth Circuit's assumptions that the Plan's independent medical examiners are biased, less capable or repeatedly used by the Plan because the Plan believes they will find a claimant able to work.

Finally, the Plan's experience shows that using a preference in favor of the treating physician's opinion would result in a situation where the Administrative Committee could not fulfill its fiduciary duty. It is not unusual that an employee claiming an inability to work, seeks to return to work immediately after disability benefits are discontinued. Since a physician's clearance is generally required to return to work, that claimant's physician often has a sudden

change of opinion and releases the claimant to work. Given this knowledge, the Plan Administrator could be forced to disregard its fiduciary duty if mandated to defer to the treating physician's view.[6]

SUMMARY OF ARGUMENT

The treating-physician rule is contrary to this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) and ERISA. It conflicts with *Firestone's* holding that decisions of a fiduciary vested with discretion will not be disturbed if they are reasonable. *Id.* at 111. It fails to recognize the fiduciary relationship of a Plan Administrator and needlessly interferes with fiduciary administration of the Plan by dictating the weight of certain evidence. As applied, the rule effectively gives the claimant's physician the right to control receipt of benefits, as opposed to the Plan Administrator. This strips the ERISA claims fiduciary of its discretion and transfers that discretion to the claimant's physician. The *fiduciary obligation and responsibility*, however, remain with the now powerless fiduciary, while the claimant's physician, who is devoid of *any* fiduciary obligation to the Plan and the other participants, wields the Plan's purse strings. For the reasons outlined below, this rule is unnecessary given the safeguards of ERISA, and its application serves to stand ERISA's framework and this Court's decision in *Firestone* on their respective heads.

The Ninth Circuit attempted to justify its decision by stating that the rule increases the consistency between

[6] Additionally, the Plan has seen claimants return to work in order to qualify for special benefits that accompany various voluntary resignation programs. These claimants too, had physicians who consistently opined the claimant could not work until the special program became available.

ERISA disability decisions and Social Security Act, 42 U.S.C. §§ 401-33, disability decisions. This ignores the fact that Congress lets ERISA Plan sponsors set the standard for disability in an ERISA Plan, but fixed a specific standard for disability under Social Security. Not only has Congress expressed no intent that these decisions should be "consistent", but it has established vastly different decision-making processes for each which reflects an expectation of divergent results. The entire structure of the Social Security Act was aimed at providing a detailed regulatory complex that left administrative law judges with only a narrow range of discretion to decide individual cases. The regulatory addition of the treating physician rule to the Social Security disability regulations, therefore, did not significantly affect the discretion of Social Security Act administrative law judges to decide claims under the Social Security Act. On the contrary, the ERISA Plan Administrator is subject to a discrete set of claims regulations promulgated by the Department of Labor which leaves the Plan Administrator's broad discretion intact.

Thus, the application of this rule affects a significant reduction in the discretion accorded to Plan Administrators under ERISA. The Ninth Circuit's desire to treat the two the same lacks any basis in logic, not to mention law.

LEGAL ARGUMENT

I. THE TREATING PHYSICIAN RULE CANNOT BE RECONCILED WITH THIS COURT'S DECISION IN *FIRESTONE*

Before examining the treating physician rule's compatibility with ERISA, it is important first to understand the rule's effect. Following this Court's decision in

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), the federal courts of appeals reached a consensus as to the standard of review applicable to cases in which the Plan administrator was vested with sufficient discretion to invoke the arbitrary or capricious standard of review. Virtually all of the courts of appeals have held that the substantial evidence test, which requires that the evidence supporting a decision be less than a preponderance of evidence, but more than a scintilla, applies when the applicable standard is arbitrary or capricious. *See, e.g., Terry v. Bayer Corp.*, 145 F.3d 28, 41 (1st Cir. 1998); *Pagan v. NYNEX Corp.*, 52 F.3d 438, 442 (2nd Cir. 1995); *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 608 (4th Cir. 1999); *Salley v. EI DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992); *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 984 (6th Cir. 1991); *Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996); *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 841-43 (8th Cir 2001); *McKenzie v. General Tel. Co. of Ca.*, 41 F.3d 1310, 1316 (9th Cir. 1994); *Woolsey v. Marion Labs., Inc.*, 934 F.2d 1452, 1460 (10th Cir. 1991); *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1452 (11th Cir. 1997).

The Ninth Circuit's decisions in *Nord* and *Regula* supplanted this *Firestone* standard by adopting the treating-physician rule. As crafted by the Ninth Circuit, that rule requires that when the treating physician and the independent physician are in conflict, the Plan administrator and/or the reviewing court *must* presume that the treating physician is correct and the independent physician is wrong unless there is substantial evidence, accompanied by "specific, legitimate" reasons for crediting the independent physician more than the treating physician. *See Regula*, 266 F.3d at 1140. Thus, while there might be

more than substantial evidence in the record as a whole to support the Plan's decision, all of that evidence would be irrelevant if between the treating physician and the independent physician the evidence was at equipoise. *Id.*

The consequence of violating the treating physician rule, as demonstrated in *Regula*, is the application of a *de novo* standard of review. *Id.* at 1145 ("If the Plan fails to carry its burden [of showing that any alleged conflict did not affect the Plan's decision] then we review *de novo* its decision denying benefits.") This is directly contrary to *Firestone* which holds that a conflict never results in *de novo* review, though it may reduce the deference afforded to the administrator. *Firestone*, 489 U.S. at 115. The rule further violates *Firestone* by conflating various steps in the process of reviewing a benefits claim decision. After *Firestone*, a court should first inquire as to whether the Plan's terms vest discretion in the Plan Administrator. *Id.* at 115. If such discretion was vested in the Plan Administrator, then the Court would move on to see whether or not there was a conflict of interest which would affect the degree of deference afforded to the Plan Administrator. *Id.* Finally, depending on which standard of review would apply, the benefit decision would be reviewed either for reasonableness under the abuse of discretion standard, or *de novo* because the Plan did not vest discretion in the administrator. *See id.* The Ninth Circuit's decision applies the treating physician rule to the middle step in the analysis, such that if the treating physicians opinion is not followed, there is little, if any, chance that the fiduciary is not operating under a conflict of interest. The Ninth Circuit's decision to create this rule for ERISA was one of judicial fiat and is not based on any precedent or logic. As demonstrated below, it is virtually impossible to avoid *de novo* review because even objectively supportable and *reasonable* factors were not accepted by the Ninth Circuit in *Regula*.

In practice, the rule is demonstrably draconian. In *Regula*, the Plan stated that the independent medical psychiatrist's opinion that Regula was malingering was based on two factors: (1) the overall examination; and (2) Regula's refusal to consider prescription drug treatment. This finding was unrebutted by the "treating" psychologist. *See id.* at 1135 (describing conflicting opinions but not noting that claimant's physician disagreed with or considered the finding of malingering). Further, the "treating" psychologist (1) indicated an improper bias in favor of Regula by assailing the report of an orthopedist and, therefore opining outside her area of expertise in the process, *id.* at 1135; and (2) proffered inconsistent opinions, *id.* at 1153 (Brunetti, J., dissenting). Moreover, the Plan preferred the opinion of the orthopedist to that of a chiropractor because it gave more credence to the opinions of medical doctors as opposed to osteopaths. (Appendix to Petition in 01-1840 at 109a (no current opinion from an M.D.)). Yet, even this was not enough for the Ninth Circuit majority as it held that not even these reasons were "specific, legitimate" reasons based on substantial evidence in the record. *Regula*, 266 F.3d at 1146-47. Given the virtually insurmountable level of evidence required by this Ninth Circuit rule as shown in its application, it is totally inconsistent with this Court's ruling in *Firestone*.

II. THE TREATING PHYSICIAN RULE CANNOT BE RECONCILED WITH ERISA GENERALLY

The Ninth Circuit's rule is also inapplicable given ERISA's structure. To the extent the rule is outcome determinative, it regulates the substantive content of an employee welfare benefit plan contrary to ERISA. *See Intermodal-Rail Employees Ass'n v. Atchison, Topeka and Santa Fe Railway Co.*, 520 U.S. 510, 515 (1997) (quoting *Metropolitan Life Ins. Co. v. Massachusetts.*,

471 U.S. 724, 732 (1985)). To the extent it portends to merely affect the claims regulation process, it is inconsistent with the claims regulations issued by the Department of Labor for ERISA benefit claims. *See* 29 U.S.C. § 2560.503-1. As a result, there is no interstice for the Ninth Circuit to create federal common law in this instance.

The rule is also inconsistent with the structure of ERISA when one focuses on the fiduciary duties assigned to those who administer the Plan. Decisions under ERISA plans are made by fiduciaries. *See Firestone*, 489 U.S. at 105. These fiduciaries are subject to ERISA's high standards that require them to act only in the best interest of Plan participants and beneficiaries. 29 U.S.C. § 1104(a)(1). ERISA prohibits fiduciaries from acting in the best interest of the Plan sponsor/employer. *See* 29 U.S.C. § 1106(b). ERISA likewise prohibits self-dealing and dealings with parties in interest. *See Harris Trust & Savings Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238, 242 (2000). Failing to comply with these rules subjects ERISA fiduciaries to *personal* liability. 29 U.S.C. § 1109(a).

Concomitant with this high level of responsibility is a broad recognition of the fiduciary discretion to make decisions under the plan when the terms of the plan vest that discretion in the fiduciary (as it is undisputed by Respondent they both did in the Black & Decker and Delta Plans). *See Firestone*, 489 U.S. at 111. When that discretion is committed to the fiduciary, the fiduciary's interpretation will not be disturbed so long as it reasonable. *Id.* As such, this Court has recognized that the fiduciary has obligation first to follow the terms of the Plan. *See Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995). This is consistent with ERISA's requirement that each benefit Plan be established and

maintained "pursuant to a written instrument." 29 U.S.C. § 1102(a)(1); *Curtiss-Wright*, 514 U.S. at 83. This requirement enables the participant to examine the Plan documents and determine their rights and obligations under the Plan. *Curtiss-Wright*, 514 U.S. at 83 (quoting H.R. Rep. No. 93-1280, at 297 (1974), 1974 U.S.C.C.A.N. 4639, 5077, 5078).

On the other hand, physicians who provide reports and opinions to benefit plans are subject to none of ERISA's fiduciary obligations. Instead, their obligations flow directly to their patients, and rightly so, *regardless* of the terms of the Plan. *See Pegram v. Herdrich*, 530 U.S. 211, 218 (2000). Indeed, this Court has previously held that even where the physician's decision regarding eligibility for a Plan benefit is mixed with a decision about medical treatment, the decision is not subject to ERISA's fiduciary obligations. *Pegram*, 530 U.S. at 231. Instead, the fiduciary duty still lies with the Plan Administrator which is solely responsible for making decisions about "distributing [benefits] to [participants and] beneficiaries." *Id.* at 231 (citing G. Bogert & G. Bogert, Law of Trusts & Trustees §§ 551, 741-47, 751-75, 781-99 (rev. 2d ed. 1980); 2A, A. Scott & W. Fratcher on Trusts, §§ 176, 181 (4th ed. 1987); 3 *id.*, §§ 188-93; 3A *id.*, § 232).

Against this backdrop of (1) a clear assignment of fiduciary duties and obligations to the Plan Administrator; and (2) a clear statement to Plan participants that they must look to the Plan Administrator as the arbiter of the Plan, the Ninth Circuit's decision improperly shifts the decision-making power to a non-fiduciary. This is contrary to ERISA's fiduciary scheme.

The Ninth Circuit's decision also violates the fundamental structure of ERISA which carefully balances the fiduciary's decision-making power with the heavy burden of fiduciary responsibility and liability. In transferring only the decision-making power, but leaving the fiduciary duty responsibility and obligations on the Plan Administrator, the Ninth Circuit has shattered the Congressional design. The result is that a party with no burden to follow ERISA is empowered to make the decisions that will affect the Plan participants, while the party that has all of the burden to make the correct decision essentially has little or no power to make the correct decision. The problem with this separation is not merely theoretical and has manifested itself in the Ninth Circuit's decisions.

The *Regula* case is a prime example. In that case, the Plan specifically stated that it was not crediting Claimant's treating psychologist because she had opined outside her area of expertise in apparent bias and sympathy for Claimant. Additionally, after first stating that Regula was psychologically ready to return to work subject to his orthopaedic limitations, she suddenly changed her opinion when the orthopaedic limitations were removed. Further, the Plan explained that with respect to the physicians, it credited the position of the orthopaedist over the chiropractor because of a preference for orthopaedists to make orthopaedic decisions. The Ninth Circuit held that this simply was not good enough to defeat the treating physician rule.

The result of the Ninth Circuit's decision in *Regula* was to shift the power to decide whether Regula's benefits would continue to (1) Regula's psychologist opining outside her areas of expertise; and (2) Regula's chiropractor, neither of whom had any *obligation* to actually follow the terms of the Plan. While they have a heavy incentive to opine in favor of their own patient's interests, and arguably an ethical obligation to do so, they owe no duty to any of the other participants or ben-

eficiaries in the Plan who have a right to know that the claims of others will be decided under the terms of the Plan by the Plan Administrator and that the assets of the Plan will not be squandered on the claims of participants who are not qualified for the Plan's benefits in accordance with those terms. Conversely, the Administrative Committee is the one entity that is in a better position to understand exactly how the Plan is evenly applied across *all* participants and beneficiaries. It also has the fiduciary responsibility under ERISA to decide claims. It now, however, has virtually no decision-making authority when the claimant's physician opines favorably to the claimant. Yet, the Plan Administrator still remains responsible to all of the other participants and beneficiaries to see that the Plan is administered and its assets spent in accordance with its terms.

The treating physician rule cannot be applied to an ERISA plan fiduciary, consistent with ERISA's structure. Under this rule, decisions regarding eligibility for benefits will not be made by the ERISA-fiduciary Plan Administrator, but by the physicians of claimants who are currently seeking benefits. These physicians are complete strangers to the Plan with no knowledge of how the Plan's disability standard has been applied previously nor responsibility to apply the terms so that the Plan's assets are preserved only for those participants eligible for the benefits. As a result, the Ninth Circuit's rule clearly contravenes ERISA's fundamental allocation fiduciary responsibility.

III. THE NINTH CIRCUIT IMPROPERLY IMPORTED A SOCIAL SECURITY REGULATION INTO ERISA

ERISA does not regulate the substantive content of employee welfare benefit plans. *Intermodal-Rail Employees Ass'n v. Atchison, Topeka and Santa Fe Railway Co.*,

520 U.S. 510, 515 (1997) (quoting *Metropolitan Life Ins. Co. v. Massachusetts.*, 471 U.S. 724, 732 (1985)). This was one way that Congress addressed the chief concern that in establishing ERISA it did not want "to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). Congress did give the Department of Labor the ability to create regulations regarding *how* ERISA benefit claims are to be decided and the Department has issued 29 C.F.R. § 2560.503-1 as a result. This regulation imposes a mechanism for benefit claimants to administratively appeal adverse benefits decisions. It includes the right of the claimant to submit information in support of the claim and to know the basis for the Plan administrator's decision. *Id.* That claim regulation specifically requires the Plan to consult an independent medical physician when it is not persuaded by the treating physician's opinion. *Id.* § 2560-503-1(h)(3)(iii) & (4). The regulation does not require that any deference be paid to the treating physician's opinion. *See id.*

Congress acted much differently in creating a public welfare benefit system under the Social Security Act. Within the Social Security Act, Congress has established an elaborate, highly-regulated public disability benefit authority. *See, e.g.*, 42 U.S.C. §§ 401-34; 20 C.F.R. § 404.1-.2127, 416.101-2227. Unlike the Delta Plan in *Regula*, the Social Security Act provides benefits even when an individual might be able to perform some work. *Heckler v. Campbell*, 461 U.S. 458, 461-62 (1983) (existence of jobs claimant can perform does not preclude disability finding). Unlike ERISA Plans, which often look at the effect of a given condition on an individual, the Social Security Act grids automatically entitle claimants with certain impairments to receipt of benefits

even if individuals with that impairment may actually be able to work. *See* 20 C.F.R. § 404.1520(d). The Social Security Act also requires a specified analysis of the job qualifications of an individual who does not meet one of these absolute criteria. 42 U.S.C. § 423(d)(2)(A); 20 C.F.R. § 404.1520(f). Much of this structure is necessary because of the sheer volume—in the millions of claims per year—that the Social Security Administration handles. *Heckler*, 461 U.S. at 464 n.2.

Despite the obvious dissimilarity of the Social Security Act and ERISA benefit schemes, the Ninth Circuit held that it was only "common sense" that the results under both should be consistent. This is wrong on at least two levels.

First, as this Court held in *Firestone*, ERISA is not based on the Social Security Act. Rather Congress intended to incorporate much of the Labor Management Relations Act's fiduciary law into ERISA. *See Firestone*, 489 U.S. at 109. Conversely, in drafting ERISA, Congress was only concerned with the Social Security Act in terms of the calculation of pension benefits, not welfare benefits. *See* 29 U.S.C. §§ 1054(b)(1)(B)(iv), 1054(b)(1)(C), 1054(b)(1)(G); *Alessi v. Raybestos-Mahhattan, Inc.*, 451 U.S. 504, 514-15 (1981) (*same*).

Second, given that the eligibility standards for benefits under an ERISA Plan are almost always different than, and usually stricter than, the Social Security standard, as is the case with Delta's Plan, there is no reason why consistency between ERISA and Social Security Act decisions should be expected. The end result of this consistency, of course, would be to reverse every Court of Appeals (including the Ninth Circuit's prior panel opinion in *Madden v. ITT Long-Term Disability Plan For Salaried Employees*, 914 F.2d 1279, 1285 (9th Cir. 1990)) which has held that an ERISA disability plan is not

bound by decisions of the Social Security, or any other, governmental benefit program. *See Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 842 n.11 (8th Cir 2001) (under the same Plan at issue in *Regula*, because of the discretion granted to the ERISA Plan Administrators, the administrator is not bound by governmental disability decisions) need not be followed by the Plan); *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1452 n. 5(11th Cir. 1997) (also concerning the same Plan as at issue in *Regula* and distinguishing the Social Security Act); *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 442-43 (2d Cir. 1995) (differing standards of disability between governmental and private Plans to preclude similar results); *Hale v. Trustees of United Mine Workers' Health & Retirement Funds*, 23 F.3d 899, 902 (4th Cir. 1994) (same). In fact, this result has already occurred in one court of appeals. *See Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 529-30 (6th Cir. 2003) (holding that an ERISA Plan which offsets benefits by Social Security Benefits may be estopped from not following the Social Security disability decision), *petition for rehearing en banc filed* (Feb. 5, 2003).

The reasoning behind the Ninth Circuit's rule supplants ERISA welfare benefit law with the law of the Social Security Act. The error of this position is manifest. Why would Congress have gone to such detail to set up two drastically different schemes if it wanted them to be the same? The answer is that Congress did not mean for them to be the same and it therefore made them drastically different. As a result, the Ninth Circuit's rule has no place.

The Ninth Circuit also thought that ERISA and the Social Security Act were similar because both ERISA Plan Administrators and Administrative Law Judges

under the Social Security Act have discretion in deciding benefit claims. It is wrong to conclude, however, that the narrow discretion under the highly regulated Social Security scheme is the same as the broad discretion of a Plan Administrator under ERISA. By analogy, both an adult and a child exercise discretion in deciding what to eat, but because the adult can drive and likely has greater wealth, the adult's discretion would involving choosing between numerous restaurants within a city. At the same time, the child's discretion would likely be between the types of food readily available in the home. The Ninth Circuit would equate these acts of choice because they both involve "discretion". The Ninth Circuit is just as wrong in justifying importation of the treating-physician rule from Social Security Act by comparing the discretion of an Administrative Law Judge under the Social Security Act and the discretion of a Plan Administrator under ERISA.

CONCLUSION

For the foregoing reasons, this Court should reverse the United States Court of Appeals for the Ninth Circuit's decision in *Nord v. Black & Decker Disability Plan*, hold that the treating-physician rule does not apply as a matter of law pursuant to ERISA and order the Ninth Circuit to enter judgment in favor of The Black & Decker Disability Plan.

This 24th day of February, 2003.

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NO. 02-469

In The
Supreme Court of the United States
October Term, 2002

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF THE ERISA INDUSTRY COMMITTEE AS AMICUS CURIAE IN SUPPORT OF PETITONER

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QUESTION PRESENTED

Whether the Ninth Circuit erred in holding that an ERISA disability plan administrator's determination of disability is subject to the "treating physician rule" and, therefore, the plan administrator is required to accept a treating physician's opinion of disability as controlling unless he rebuts that opinion based upon substantial evidence on the record.

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In The
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THE BLACK & DECKER DISABILITY PLAN,

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Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE ERISA INDUSTRY COMMITTEE AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

The ERISA Industry Committee ("ERIC") respectfully submits this brief *amicus curiae* in support of petitioner Black & Decker Disability Plan. Letters from

petitioner and respondent indicating consent to file have been filed with the Clerk. [1]

INTEREST OF AMICUS CURIAE

ERIC is a nonprofit organization representing America's largest private employers that maintain ERISA-covered pension, healthcare, disability, and other employee benefit plans, providing benefits to millions of active workers, retired persons, and their families nationwide. All of ERIC's members do business in more than one State, and many have employees in all fifty States. ERIC frequently participates as amicus in cases with the potential for far-reaching effect on employee benefit plan design or administration.[2]

ERIC and its members have a vital interest in this case, which imports into the disability plans administered by private employers the "treating physician rule" used in determining disability claims under Titles II and XVI of the Social Security Act. That holding deprives employers of the discretion afforded them under ERISA with respect to plan design and plan administration and, if upheld, will cause additional expense in the administration of plans, to the detriment of both the employers and employees whose contributions fund them.[3]

Because of the importance of these issues to ERIC and its members, ERIC respectfully submits this brief urging the Court to reverse the decision below and reject application of the treating physician rule to ERISA disability determinations.

SUMMARY OF ARGUMENT

While both the Employee Retirement Income Security Act ("ERISA") and the Social Security Act involve disability programs subject to federal court review, their statutory and regulatory schemes are by no means interchangeable, and the procedures that apply to one are inappropriate for the other.

ERISA governs the design and administration of pension and welfare plans established by employers for their employees. ERISA does not require employers to establish employee benefit plans, nor does it define the benefits that must be provided or the method of calculating those benefits. *See Lockheed v. Spink,* 517 U.S. 882, 885 (1996). ERISA does, however, promise "a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." ERISA § 503, 29 U.S.C. § 1133.

Pursuant to that statutory provision, the Department of Labor recently completed a major review and overhaul of

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[1] Pursuant to Rule 37.6, amicus states that no counsel for any petitioner or respondent authored this brief in whole or in part. No person or entity, other than ERIC and its members, made a monetary contribution to the preparation or submission of this brief.

[2] *See, e.g., Hughes Aircraft Co. v. Jacobson,* 525 U.S. 432 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

[3] These costs are not borne solely by employers. Because of the favorable tax consequences to benefit recipients, many disability plans are funded through after-tax employee contributions. *See* Ken McDonnell, *Disability Income: Voluntary Employment-Based Plans* 9 (EBRI Notes June 2002).

its regulations governing claims procedures for group health and disability plans, including the process for review of adverse benefit determinations and the need for medical consultations. Those regulations strive to reconcile "the need for procedural protections with the purely voluntary nature of the system through which these vital benefits are delivered." 65 Fed. Reg. 70246, 70246 (Nov. 21, 2000). The newly promulgated rules do call for consultation with medical professionals in certain circumstances but nowhere require plans to defer to a claimant's treating physician.

The "treating physician" rule that the Ninth Circuit imposed on the ERISA plan below appears to be based on that used in making disability determinations under the Social Security Act. That rule was adopted by the Social Security Administration upon injunction from the U.S. Court of Appeals for the Second Circuit and is premised on the Act being "a remedial statute, to be broadly construed and liberally applied." *Gold v. Secretary of Health, Educ. and Welfare*, 463 F.2d 38, 41 (2d Cir. 1972) (quoting *Haberman v. Finch*, 418 F.2d 664, 667 (2d Cir. 1969)); *Schisler v. Sullivan*, 3 F.3d 563, 567-68 (2d Cir. 1993) (reciting history). The Social Security regulations gives the opinion of the claimant's treating physician controlling weight unless rebutted by substantial evidence in the case record. In a variant of that rule, the court below held that a plan administrator could depart from the opinion of the treating physician only by giving "specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Nord v. Black & Decker*, 296 F.3d 823, 831 (9th Cir. 2002).

The treating physician rule adopted by the court below has the effect of transferring the burden of persuasion from the claimant to the plan administrator, and it has generally not been considered to be appropriate outside of the massive disability insurance programs administered by the Social Security Administration. Courts have rejected its

application to reviews of claims for Medicaid or veterans benefits, for example, and it likewise should be rejected here. The ERISA regulatory regime already imposes on plan administrators a fiduciary obligation to participants and beneficiaries and puts in place procedures to ensure plan participants a full and fair review of any disability determination that makes the remedial presumptions of the treating physician rule both unnecessary and out of place.

ARGUMENT

I. The Treating Physician Rule Has No Place In ERISA.

ERISA was enacted in 1974 to "safeguar[d] . . . the establishment, operation, and administration" of employee benefit plans by setting "minimum standards . . . assuring the equitable character of such plans and their financial soundness." 29 U.S.C. 1001(a). The statute does not require employers to establish employee benefit plans, nor does it define the benefits that must be provided or the method of calculating those benefits. *See Lockheed v. Spink*, 517 U.S. 882, 885 (1996); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court addressed the standard of review for actions, such as this one, in which a plan participant brings suit under ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), claiming that he has been denied benefits to which he is entitled under the terms of a plan governed by ERISA. Following trust law principles, the Court held that a deferential standard of review is appropriate when the plan administrator or other fiduciary is authorized to exercise discretionary power to construe the terms of the plan. *Id.* at 115. The Court also stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as

a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

Although the plan in question gives discretion to the plan administrator in making disability determinations, the Ninth Circuit declined to review the decision under the abuse of discretion standard called for in *Firestone,* and instead concluded that it should review the administrator's decision *de novo* because the rejection of the opinion of respondent's treating physician was material evidence that the administrator's decision was colored by the "inherent conflict of interest" in Black & Decker's dual role "as the administrator and funding source for the plan." *Nord*, 296 F.3d at 829. Applying *de novo* review, the court also found that the departure from the treating physician's opinion was an abuse of discretion. The Ninth Circuit decision changes a denial of benefits review from a case in which the claimant must show an entitlement to benefits to one where the plan administrator bears the burden of establishing that the opinion of the treating physician is wrong. Nothing in the statute or the administrative regime it creates can support that result.

The overriding principle of ERISA is that benefits are governed by the language of the plan itself. *See Firestone*, 489 U.S. at 115. Requiring all employers to abide by the treating physician rule despite the uniqueness of each plan is precisely what ERISA is not intended to do. *See Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 732 (1985) (ERISA does not "regulate the substantive content of welfare-benefit plans."). ERISA neither contemplates nor requires a mandatory application of the treating physician rule. Rather, ERISA requires basic procedural safeguards in the determination of benefit plans and appeals. *See* 29 U.S.C. § 1133. In furtherance of that goal, Section 503 of ERISA delegates to the Department of Labor the authority to promulgate rules that will "afford a

reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." ERISA § 503, 29 U.S.C. § 1133.

Pursuant to Section 503, the Department of Labor recently overhauled the regulations governing the processing of benefit claims under ERISA-covered disability plans, effective for all claims filed after January 1, 2002. *See* 65 Fed. Reg. 70246 (Nov. 21, 2000). The new standards for handling disability claims are "intended and expected to improve the timeliness and accuracy of disability benefit claims determinations," "increase enrollee confidence in disability plans," and "promote efficiency in disability insurance and labor markets." *Id.* at 70261. As a general rule, an ERISA-covered disability plan must "contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants." *Id.* at 70266.[4]

The new rules provide, among other things, that a claimant must have (i) the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits, upon request and free of charge; and (iii) a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without

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[4] The Department of Labor's interpretation of the proper balance between plan flexibility and required procedures is instructive, even though the particular claim at issue was processed prior to the new regulations being in effect.

regard to whether such information was submitted or considered in the initial benefit determination. 29 C.F.R. § 2560.503-1(h)(4).

In addition, claimants have the right to appeal an adverse benefit determination to an appropriate named fiduciary of the plan. If the determination is based "in whole or in part on a medical judgment," the fiduciary must "consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment." A consulting health care professional cannot have been consulted in connection with the adverse benefit determination that is the subject of the appeal, nor be the subordinate of any such individual. 29 C.F.R. § 2560.503-1(h)(3)(iv-v).

Subsequent guidelines issued by the Department explain that the requirement of consultation "is intended to ensure that the fiduciary deciding a claim involving medical issues is adequately informed as to those issues." The guidelines go on to state that "[i]n all cases, a fiduciary must take appropriate steps to resolve the appeal in a prudent manner, including acquiring necessary information and advice, *weighing the advice and information so obtained*, and making an *independent* decision on the appeal." Benefit Claims Procedure Regulations Frequently Asked Questions, U.S. Dept. of Labor Q-D8 (visited February 20, 2003), <http://www.dol.gov/ebsa/FAQs/faq_claims_proc_reg.html> ("hereinafter "BCPR FAQ") (emphasis added).

The Department has concluded that its regulation strikes the appropriate balance between the need for "accuracy," "enrollee confidence in disability plans," and "efficiency in disability insurance prescribe and labor markets." 65 Fed. Reg. at 70261. As its subsequent guidance explains:

> The Department did not intend to *any particular process or safeguard* to ensure and verify consistent decision making by plans. To the contrary, the Department intended to *preserve the greatest flexibility possible* for designing and operating claims processing systems consistent with the prudent administration of a plan.

BCPR FAQ, *supra*, Q-B4 (emphasis added).

Contrary to this intent to preserve the "greatest flexibility possible," the Ninth Circuit has prescribed a specific and "particular process" that ERISA plans must follow in making disability determinations. According to the court, a plan administrator must accept the opinion of the treating physician unless it gives "specific, legitimate reasons for doing so that are based on substantial evidence in the record." 296 F.3d at 831. The articulation of that rule is a more stringent variation of the treating physician rule followed by the Social Security Administration in making disability determinations under its Disability Insurance ("SSDI") and Supplemental Security Income ("SSI") programs, which gives "a treating source's opinion on the issue(s) of the nature and severity of [the] impairment(s)" if that opinion is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] case record." 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2).

The court below justified its importation of the treating physician rule into ERISA on the theory that plan administrators faced a conflict of interest in reviewing disability claims. But plan administrators and fiduciaries that make disability determinations are bound to discharge their duties solely in the interest of participants and beneficiaries. 29 U.S.C. § 1004(a). In exercising those responsibilities, among other things, employers and

employees called upon to make or review benefit determinations must follow the claims procedures established by the Department of Labor. They must ensure that plan provisions are "applied consistently with respect to similarly situated claimants," provide for several levels of review, and at each level consult with appropriate health care professionals. 29 C.F.R. § 2560.503-1(h)(3). The fiduciary must "weigh[] the advice and information so obtained" and make an "independent decision" on the determination. *See* BCPR FAQ, *supra*, Q-D8.

Even if the Ninth Circuit is correct that there is an inherent conflict of interest in an employer's dual role as the funding source and administrator of a disability plan--and putting aside the question of plans funded through assets that by definition cannot revert to the employer, as is frequently the case with employer-sponsored disability plans[5]--the Department of Labor has already taken account of that dual role by establishing detailed and specific claims procedures "to ensure and to verify that benefit claims determinations are made in accordance with governing plan documents." 65 Fed. Reg. at 70266. In light of those required procedures, there is no vacuum that would make it appropriate for a court to fill in the gaps through federal common-law making, as the court did below. *Cf. Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987).

Available data also shows no evidence that there is any conflict of interest that impedes employers or plan administrators in the exercise of their fiduciary duties in making and reviewing determinations for disability benefits.

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[5] *See, e.g., Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270 (11th Cir. 2002); *Abnathya v. Hoffman-La Roche, Inc.*, 2 F.3d 40, 45 n. 5 (3d Cir. 1993); *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998).

According to the Department of Labor, 36 million U.S. private-sector employees (or 32 percent of all such employees) are insured against short-term disability through employer-sponsored plans, and 26 million (or 23 percent) are insured against long-term disability. 65 Fed. Reg. at 70261. The Department of Labor also estimates that there are some 1,716,000 disability plans operating in the United States, and that together they process 1,389,700 claims a year, of which the overwhelming majority (1,304,900) are approved. *Id.* at 70263.

By contrast, in calendar year 2001, approximately 1.5 million claims for SSDI disability benefits were filed, with benefits being awarded in only 46.1 percent of cases. *See* Selected Data from Social Security's Disability Program (visited February 20, 2003) <http:// www.ssa.gov/ OACT/STATS/table6c7.html>. In the same year, there were approximately 1.5 million new applications and only 665,000 new entrants for SSI benefits based on blindness or disability. 2002 SSI Annual Report (visited Feb. 20, 2003) <http://www.ssa.gov/OACT/SSIR/SSI02/Participants_1.html .21334>.

The court below was simply incorrect in its assumption that that the treating physician rule is equally at home in all manner of disability determinations. In a similar context, the New York Court of Appeals held that application of the treating physician rule would be inappropriate in the Medicaid program because that program "confers broad discretion on participating States to determine the extent of services provided." *See Kuppersmith v. Dowling*, 710 N.E.2d 660, 662 (N.Y. 1999). Accordingly, the court rejected a class challenge to State Medicaid regulations on the ground that they did not accord sufficient weight to treating physicians' assessment of the scope of home health care services that must be provided in specific cases.

Likewise, in *White v. Principi*, 243 F.3d 1378, 1379 (Fed. Cir. 2001), the Federal Circuit rejected the argument that the Court of Appeals for Veterans Claims had "erred as a matter of law when it failed to adopt the 'treating physician' rule, which would require that additional evidentiary weight be given to the opinion of a physician who had treated her husband." The Federal Circuit found that the treating physician rule was "specifically designed" to address conflicts of opinion inherent in the Social Security disability determination process. *See id.* at 1380. Moreover, the court found that while the treating physician rule was consistent with the statutory scheme of Social Security, according additional weight to any one factor may conflict with a statute providing that Veterans Benefits determinations should be made on the basis of entire record. *See id.* at 1381 (citing 38 U.S.C. § 7104(a)). *See also Knudsen v. Department of Health and Human Servs.*, No. 90-2067V, 1992 WL 395631, at *6-*7 (Fed. Cl. Dec. 17, 1992) (holding that treating physician rule conflicts with National Vaccine Injury Compensation Program regulations requiring fact finder to consider entire record).

There is no room in ERISA for the treating physician rule. While its application may be appropriate for the massive Social Security disability insurance programs, which are "to be broadly construed and liberally applied," *Gold v. Secretary of HEW*, 463 F.2d 38, 41 (2d Cir. 1972), it is completely out of place under ERISA. As acknowledged in the rules for claims procedures, ERISA accords employers a great deal of flexibility to design their own plans, *see, e.g., Lockheed*, 517 U.S. at 885, but also imposes fiduciary obligations on the administrators of those plans to administer the plans fairly and consistently.

In sum, contrary to the decision below, it is neither "material evidence" of a conflict of interest or an abuse of discretion for a plan administrator to question or reject the opinion of a treating physician on the basis of other evidence

in the case record as a whole, and the opinion below should be reversed accordingly.

CONCLUSION

For all of these reasons, as well as those set forth in the brief for petitioner, amicus respectfully urges the Court to reverse the decision below.

Respectfully submitted,

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Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,
Petitioner,

v.

KENNETH L. NORD,
Respondent.

On Writ of Certiorari to the United States Court Of Appeals for the Ninth Circuit

BRIEF OF THE AMERICAN BENEFITS COUNCIL AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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BRIEF OF THE AMERICAN BENEFITS COUNCIL AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

This brief is submitted on behalf of the American Benefits Council as *amicus curiae* in support of petitioner, with the written consent of the parties.[1]

INTEREST OF AMICUS CURIAE

The American Benefits Council ("ABC"), is a broad-based nonprofit trade association founded to protect and foster the growth of this Nation's effective and important privately sponsored employee benefit plans. The members of ABC include both small and large employer sponsors of employee benefit plans, as well as plan support organizations,

[1] Letters of consent have been filed with the Clerk. No counsel for a party authored this brief in whole or in part, and no person or entity other than *amicus* or its counsel made a monetary contribution to this brief.

such as consulting and actuarial firms, investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 250 members sponsor, administer or advise plans covering more than 100 million plan participants. ABC has filed *amicus* briefs in other cases before this Court raising issues of concern to employers, insurers, and employee benefit plan support entities. *See, e.g., Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

SUMMARY OF ARGUMENT

The decisions of the Ninth Circuit applying the "treating physician rule" to review of private disability benefit plan eligibility determinations cannot be squared with the principles of discretion and deference that properly govern judicial review of such determinations.

I. The choice whether to provide a disability plan is entirely up the employer, as is the decision whether to confer discretion on the plan administrator to make eligibility determinations. If the employer decides to confer such discretion, then a court must respect that choice and give wide deference to the administrator's eligibility decision, setting it aside only if it reflects an abuse of the administrator's discretion. This is true even where the administrator is operating under a potential conflict of interest: a court should apply less deferential review in that circumstance only where the claimant produces specific evidence, beyond the mere fact of the potential conflict, establishing that the administrator's judgment was *actually influenced* by an improper motive.

II. The "treating physician rule" conflicts with the foregoing principles. As applied in recent Ninth Circuit cases, the rule requires a plan administrator to accept as controlling the opinion of an employee's treating physician that the employee is "disabled" within the meaning of the plan, unless the administrator can point to specific facts showing that the

opinion is not reliable. The rule ignores the fact that a "disability" determination often involves much more than just a purely medical judgment – it involves the application of what are often subjective medical issues to disability plan language and flexible job requirements. Treating physicians typically have no experience or expertise in interpreting employee benefit plans or in evaluating how job requirements may be altered to keep an employee with a medical problem on the job. Even to the extent purely medical judgments are involved, an administrator does not abuse its discretion where, as here, it chooses to rely on the medical judgment of an independent consulting physician rather than on the opinion of the employee's own physician. Treating physicians are not necessarily more "objective" than consulting physicians; indeed, they have a strong duty of loyalty to their patients, and no duty whatsoever to employers and other plan beneficiaries. More important, disability determinations are often highly subjective, and the fact that two doctors disagree does not mean that either's opinion is unreasonable. And choosing between two reasonable opinions is the essence of discretion.

Nor can the treating physician rule be justified as a device for determining whether an administrator operating under a potential conflict of interest was actually influenced by the improper, potentially conflicting interest. The mere fact that an administrator decides not to follow the treating physician's opinion does not amount to the kind of specific evidence of improper influence that should be required before a court applies less deferential review to the administrator's judgment. An administrator's decision to follow the consulting physician rather than the treating physician is not specific evidence of improper influence – it is only evidence that the administrator, in the exercise of its discretion, disagreed with the treating physician. There is no basis for an inference of bad motive from such disagreement: treating physicians know comparatively little or nothing about job requirements,

and treating physicians are subject to their own potentially conflicting interests. Even more important, ERISA and this Court's opinions recognize that most fiduciaries live up to their fiduciary obligations, until it is proved otherwise. Further, Department of Labor regulations, recently revised and strengthened, provide additional procedural safeguards for plan participants, including safeguards specifically directed toward ensuring that plan administrators have a sound, impartial basis for their disability determinations. The treating physician rule supplants all of that with a presumption of bad faith, grounded on the deeply flawed premise that a treating physician opinion is typically so valuable that only an improperly influenced administrator would reject it in the absence of evidence that the opinion is unreliable. That view vastly overstates the value of such opinions and greatly understates the professionalism and responsibility of the typical plan administrator.

ARGUMENT

The question in this case is whether the plan administrator or named fiduciary of an ERISA-governed employee disability benefits plan must accord deference to the opinion of an employee's own doctor that the employee is "disabled" within the meaning of that term under the plan – even where the plan confers discretion on the plan administrator to decide whether an employee qualifies as "disabled." The answer is no.

The "treating physician rule" requires a plan administrator to give controlling weight to the conclusion of the employee's "treating physician" that the employee is "disabled" under the plan, unless the plan administrator can identify "specific, legitimate reasons" for rejecting the treating physician's conclusion. Pet. App. 13. It is not enough under the rule for the administrator (even when reviewing the initial denial of a claim by an independent entity with no financial interest in the claim), to rely upon the conclusions of a consulting physician retained by the plan, *id.* at 14, or on the administrator's own experience and judgment about the demands of the employee's position. Rather, the administrator must point to substantial evidence tending to prove that the treating physician's opinion was "unreliable and [the independent physician's] more reliable," or that the treating physician "considered inappropriate factors" in deciding the employee was disabled, or that the physician "lacked the requisite medical expertise" to reach such a decision. *Id.* at 13-14.

There is no context in the administration of any ERISA-governed disability plan in which it is appropriate for a court to impose that kind of burden on a plan administrator. Doing so runs afoul of two principles fundamental to the administration of ERISA-governed disability plans. First, ERISA does not compel employers to provide any disability benefits at all. The decision whether to provide such benefits, and if so, what benefits to provide, rests entirely with the employer. As part of that decision, the employer has complete freedom to establish the substantive requirements for receiving disability benefits under the plan – to define what constitutes a qualified "disability," for example. Second, and relatedly, if an employer decides to provide a disability benefit plan, it may vest in the plan administrator complete discretion to determine whether a given employee satisfies the plan's requirements for benefits, including whether the employee qualifies as "disabled" within the meaning of the plan. If a plan does confer such discretion on the administrator – as does the plan at issue here – a court reviewing an eligibility determination as part of a suit for benefits under ERISA must accord wide deference to the administrator's judgment, reversing its decision only if the court finds an actual abuse of discretion by the administrator.

The treating physician rule cannot be reconciled with these essential principles of employer choice, discretion and deference. To say that a plan administrator *must* defer to the

treating physician is to say, by definition, that the administrator *cannot* exercise discretion. It is fundamentally to shift authority to administer the plan away from the plan administrator, and over to both the treating physician and the reviewing court. Nothing in ERISA, its governing regulations, or this Court's precedents, supports that result – and much contradicts it. The judgment should be reversed.

I. BASIC ERISA AND TRUST LAW PRINCIPLES COMPEL WIDE JUDICIAL DEFERENCE TO A PLAN ADMINISTRATOR'S EXERCISE OF DISCRETION IN DETERMINING BENEFIT ELIGIBILITY, EVEN WHERE THERE IS A POTENTIAL CONFLICT OF INTEREST

ERISA neither compels employers to establish disability benefit plans, nor restricts the freedom of employers to define the disability benefits they choose to provide. *See Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 71, 78 (1995). ERISA's safeguards are essentially contractual and procedural in nature: where an employer decides to establish a disability benefit plan, ERISA "simply requires [the] plan[s] to afford a beneficiary some mechanism for internal review of a benefit denial, 29 U.S.C. § 1133(2), and provides a right to a subsequent judicial forum for a claim to recover benefits, § 1132(a)." *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2169 (2002).

In accordance with the employer's discretion to define the disability benefits available under a plan, an employee's entitlement to benefits is controlled by the terms of the employer's plan. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981). At the same time, the employer may decide to confer discretion on the plan administrator[2] to "de-

[2] ERISA requires that all plans be administered by a "named fiduciary," 29 U.S.C. § 1102(a)(1), typically referred to as the "plan administrator" (the Black & Decker Disability Plan labels the position "Plan Manager"). Named fiduciaries other than the plan administrator may also be designated to administer claims. *Id.* References in this brief to the "plan administrator" include such named fiduciaries.

termine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

When a benefit plan includes such a provision, the court's power to review a plan administrator's discretionary eligibility determination is highly circumscribed. *Id.* As the Court explained in *Firestone*, under principles of trust law that guide the application of ERISA in this area, where "discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion." *Id.* at 111 (quoting Restatement (Second) of Trusts § 187 (1959) ("Restatement")). A court "*will not interfere to control* [trustees] in the exercise of a discretion vested in them by the instrument under which they act." *Id.* at 111 (quoting *Nichols v. Eaton*, 91 U.S. 716, 724-25 (1875) (emphasis altered)). In the law of trusts, "[t]he cases are numerous in which it has been held that where discretion is conferred upon the trustee with respect to the exercise of a power the court will not interfere with him in his exercise or failure to exercise the power so long as he is not guilty of an abuse of discretion." III Scott & Fratcher, The Law of Trusts ("Scott on Trusts") § 187 (4th ed. 1988).

Although based soundly in trust law, the principle of deference to the discretionary decisions of the plan administrator also fits hand-in-glove with Congress's determination to leave employers free to establish the substantive terms of the welfare benefit plans they choose to provide. An employer could of course decide that employees are better off if any individual claimant who is denied benefits can bring a judicial action in which the court will review the denial *de novo*

and decide for itself whether the claimant should receive the benefit sought in that case. But in such a case the court would evaluate just the merits of the individual claim before the court. The court would have little basis for considering the overall, and often subjective, long-term interests of the plan and its other beneficiaries. Nor would the court have the expertise to do so. The judicial ken is to decide cases-and-controversies – not to run employee welfare plans.

Given that obvious drawback (among others) of leaving the administration of disability plans to the federal courts, employers are much more likely to decide that it is better for all concerned if the plan confers the discretion to make individual eligibility decisions on an expert professional with authority to administer the overall plan, and a fiduciary responsibility to do so in the best interests of the plan and all its participants. If an employer decides to confer such discretion on the plan administrator, courts must respect that plan design decision as much as they must respect any other. Accordingly, when an administrator makes an eligibility determination, a court adjudicating a challenge to that determination must defer to the exercise of the administrator's discretion. *See Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1006 (4th Cir. 1985) (deferential review "exists to ensure that administrative responsibility rests with those whose experience is daily and continuous, not with judges whose exposure is episodic and occasional").[3]

The limited role left for a court in such circumstances is to determine whether the administrator abused its discretion. *Firestone*, 489 U.S. at 115; Restatement § 187; III Scott on Trusts § 187. As the lower courts have applied that standard of review, the administrator's eligibility decision will be up-

[3] *Amicus* ABC can attest that since *Firestone* made clear 14 years ago that a court must give deference when the plan confers discretion on the plan administrator, numerous employers and plan sponsors have added such provisions to their plans in reliance on *Firestone*.

held (absent a conflict of interest, *see infra* note 5) so long as it is supported by "substantial evidence." *See Fletcher-Merritt v. NorAm Energy Corp.*, 250 F.3d 1174, 1179 (8th Cir. 2001); *Meditrust Fin. Servs. Corp. v. Sterling Chemical, Inc.*, 168 F.3d 211, 215 (5th Cir. 1999); *Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2d Cir. 1995); *Abnathya v. Hoffman-LaRoche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993); *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 382 (10th Cir. 1992). As in the administrative law context from which the standard is familiar, "substantial evidence" means only enough evidence that a "reasonable person could have reached the same decision as the plan administrator." *Fletcher-Merritt*, 250 F.3d at 1180; *see Miller*, 72 F.3d at 1072; *Sandoval*, 967 F.2d at 382; *cf. NLRB v. Columbian Enameling*, 306 U.S. 292, 300 (1939); *Consol. Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). It requires more than a mere scintilla of evidence, but less than a preponderance. *See Meditrust*, 168 F.3d at 215; *Miller*, 72 F.3d at 1072; *Sandoval*, 967 F.2d at 382; *cf. Multimax, Inc. v. FAA*, 231 F.3d 882, 887 (D.C. 2000); *New Valley Corp. v. Gilliam*, 192 F.3d 150, 154 (D.C. 1999).[4]

This Court's explanation of the virtue of the deferential "substantial evidence" standard in reviewing administrative agency decisions could just have easily been summarizing the importance of deferring to the discretionary eligibility decision of an ERISA plan administrator:

> [The "substantial evidence" standard] frees the reviewing courts of the time-consuming and difficult

[4] The "substantial evidence" standard is the same as the standard applied to review of jury verdicts, *see Columbian Enameling*, 306 U.S. at 300; hence, it is much more deferential than the "clearly erroneous" review afforded judicial factfinders. *See* Stern, *Review of Findings of Administrators, Judges and Juries: A Comparative Analysis*, 58 Harv. L. Rev. 70, 88-89 (1944); Pierce, Administrative Law Treatise § 11.1, at 768-69 (4th ed. 2002).

> task of weighing the evidence, it gives proper respect to the expertise of the [administrator] and it helps promote the uniform application of the [plan]. These policies are particularly important when a court is asked to review an [administrator's discretionary eligibility determination]. In this area [administrator] determinations frequently rest on a complex and hard-to-review mix of considerations. By giving the [administrator] discretionary power to [make eligibility decisions], [the employer] places a premium upon [the administrator's] expertise, and, for the sake of uniformity, it is usually better to minimize the opportunity for reviewing courts to substitute their discretion for that of the [administrator].

Consolo v. Federal Maritime Comm'n, 383 U.S. 607, 620-21 (1966).

Finally, it bears noting that this highly deferential standard should not become less deferential merely because the plan administrator is operating under a potential conflict of interest. This Court stated in *Firestone* that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement § 187 comment d). Ever since, the lower courts have been in disarray over how the existence of a conflict "weighs" in the review of a discretionary eligibility determination.[5] Perhaps

[5] One court of appeals says that the mere existence of a potential conflict shifts the burden to the plan administrator to show that his decision was untainted by the conflict. *See Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1566-68 (11th Cir. 1990). Other courts have adopted a "sliding scale" approach, under which the degree of deference turns on the extent of the potential conflict – the greater the potential conflict, the more closely the court will scrutinize the plan administrator's exercise of discretion. *See, e.g., Pitman v. Blue Cross*, 217 F.3d 1291, 1295 (10th Cir. 2000); *Pinto v. Reliance Std. Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir. 2000); *Vega v. National Life Ins. Serv., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (en banc). Still other courts hold that fully deferential, abuse-of-discretion review still obtains, unless and until the claimant produces "material, probative evidence, *beyond the mere fact of the apparent conflict*, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995) (emphasis added). If, but only if, the claimant does come forward with "further evidence" in the form of "specific facts" showing that the administrator actually acted on the basis of the potentially conflicting interest, the burden shifts to the administrator to disprove that inference. *See id.* at 1322-23; *see also Clapp v. Citibank N.A. Disability Plan*, 262 F.3d 820, 827 (8th Cir. 2001) (court gives less deferential "sliding scale" review only if claimant produces "material, probative evidence" that a "palpable conflict" was actually connected to administrator's decision so as to "cause[] serious breach" of fiduciary obligation). Two other circuits follow the same approach, but add that the claimant's burden is more than just one of production – the claimant at all times bears "the burden of proving that the conflict of interest affected the administrator's decision." *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996); *see Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998).

cognizant of that confusion, this Court itself recently raised the question of "just how deferential the review [of an eligibility determination] can be when the judicial eye is peeled for conflict of interest." *Rush Prudential*, 122 S. Ct. at 2169 n.15.

The Court did not try to grapple with that question, but the answer turns out to be quite clear: the very trust principles relied upon in *Firestone* hold that a trustee who is operating under a conflict of interest abuses its discretion only when the evidence establishes that the trustee was actually motivated by the conflicting interest. As the Restatement explains:

> The court will control the trustee in the exercise of a power . . . where he acts from a motive other than to further the purposes of the trust. Thus, if the trustee in exercising or failing to exercise a power does so

> . . . to further some interest of his own or of a person other than the beneficiary, the court will interpose. *Although ordinarily the court will not inquire into the motives of the trustee, yet if it is shown that his motives were improper or that he could not have acted from a proper motive, the court will interpose.*

Restatement § 187 comment g (emphasis added). That a trustee is operating under a conflict is only a fact "to be considered" in determining whether the trustee was actually motivated by the improper, conflicting interest. *Id.* In other words, basic trust principles support the general approach of those circuits holding that the review of a plan administrator's discretionary eligibility determination remains fully deferential, even when the judicial eye spots a conflict of interest, unless and until the claimant produces specific evidence (beyond the conflict itself) establishing that the conflict actually caused the administrator to act contrary to the interests of the plan beneficiaries. *See supra* note 5.[6]

Although the Ninth Circuit has adopted a version of that approach, *see Atwood*, *supra*, 45 F.3d at 1323, it has been basically nullified where treating physician opinions are involved. As we show in the next section, the court's adoption of the treating physician rule eviscerates the twin principles of discretion and deference that apply to judicial review of ERISA disability benefit plan eligibility determinations, even

[6] Whether the burden is one of proof or of production is not answered by trust law principles, but by settled rules of pleading: shifting "the burden of proof to the defendants is contrary to the traditional burden of proof in a civil case." *Sullivan*, 82 F.3d at 1259; *cf. St. Mary's Honor Ctr. v. Hicks*, 509 U.S. 502, 507 (1993) (burden of persuasion under Federal Rules of Evidence always rests with plaintiff). Accordingly, the burden at all times should be on the claimant to prove that a conflict exists and that the conflict actually affected the decision. *See Sullivan*, 82 F.3d at 1259; *Doyle*, 144 F.3d at 184.

where the administrator is operating under a potential conflict of interest.

II. THE TREATING PHYSICIAN RULE CONFLICTS WITH THE DEFERENCE COURTS OWE TO A PLAN ADMINSTRATOR'S DISCRETIONARY ELIGIBILITY DETERMINATIONS

The Ninth Circuit has thus far applied the treating physician rule only in the context of a plan administrator operating under a potential conflict of interest. The court uses the rule as an evidentiary device for determining whether a potentially conflicting interest in fact provided the plan administrator's true motivation. According to the Ninth Circuit, where a claimant shows that a plan administrator subject to a potential conflict has "reject[ed] the opinions of the [claimant's] treating physicians," the claimant has produced "material, probative evidence" that the "apparent conflict of interest has ripened into an actual, serious conflict, thereby permitting the court to engage in de novo review." *Regula v. Delta Family-Care Survivorship Plan*, 266 F.3d 1130, 1147 (9th Cir. 2001), *petition for cert. pending*, No. 01-1840. To permissibly reject a treating physician's opinion under this rule, a potentially conflicted administrator must rely on more than the conclusion of an independent consulting physician that the employee is not disabled, and more than the administrator's own investigation and knowledge of the employee's job position requirements. Rather, the administrator must point to additional evidence specifically *dis*proving the accuracy or reliability of the treating physician's conclusions. Pet. App. 13-14.

Although the Ninth Circuit's specific applications of the rule have to date been only in cases involving potential conflicts of interest, the court's earlier opinion in *Regula* contained a more extensive discussion of why a court should apply the treating physician rule even where there is no conflict of interest issue and review is only for abuse of discre-

tion. *See* 266 F.3d at 1139 ("we see no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions"); *id.* at 1140-41 ("we do not believe that the treating physician rule is inconsistent with the broad discretion accorded plan administrators under *Firestone*"); *see generally id.* at 1139-44. Nor is the Question Presented in the petition for certiorari in this case explicitly limited to the application of the treating physician rule where potential conflicts are involved. *See* Pet. i. Accordingly, we begin by explaining why the treating physician rule is inconsistent with the wide deference a court generally owes to an administrator's discretionary eligibility determinations. We then explain why it also should not be applied to eliminate the deference a court would otherwise owe even to an administrator operating under a potential conflict.

A. The Treating Physician Rule Improperly Restricts Both The Administrator's Discretion And The Deference Courts Owe That Discretion

As articulated by the Ninth Circuit in its recent cases, the treating physician rule requires a plan administrator evaluating a claim for disability benefits to give deference to the opinion of the treating physician that the employee is "disabled" within the meaning of the plan. *Regula*, 266 F.3d at 1139. Such deference is "not absolute," *id.* at 1140, but it is considerable. The administrator may reject the treating physician's opinion only if the administrator can identify "specific, legitimate reasons for doing so." *Id.* The contrary opinion of an independent consulting physician will not suffice, in and of itself, to rebut the treating physician's view; the administrator must point to "other evidence in the record." *Id.* The consulting physician's opinion, together with the "other evidence," must tend to show that the treating physician's opinion is not reliable. Pet. App. 13-14. That

rule cannot be reconciled with fundamental principles governing review for abuse of discretion.

1. To begin with, even indulging the Ninth Circuit's mistaken assumption that "eligibility for [disability] benefits turns almost entirely on medical professionals' opinions as to the claimants' impairments," *Regula*, 266 F.3d at 1141, there is no question but that a plan administrator typically would be entitled to rely entirely on the opinion of an independent consulting physician. A plan administrator's discretionary eligibility determination need be supported only by "substantial evidence" – i.e., enough evidence that "a reasonable person could have reached the same decision as the plan administrator." *Fletcher-Merrit*, 250 F.3d at 1180; *see supra* at 8-10. So long as the consulting physician is not shown to be unreliable, incompetent, or actually biased, it would be the rare case in which no reasonable person could believe that the consulting physician's opinion was correct.

Of course, the opinion of the consulting physician must be viewed as part of the record as a whole, which would include the opinions of the treating physicians. *Cf. Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951) (substantial evidence determined on basis of record as whole). But unless the claimant can show that the consulting physician's opinion does not reflect a reasoned and reasonable medical judgment, the mere fact that another physician disagrees would not undermine the reasonableness of the administrator's decision to rely on one opinion rather than the other. The medical judgment involved in a disability determination is often highly subjective: how much pain does the employee suffer? how long can she sit or stand? how many breaks will help? what kinds of changes of position would help? how much can she lift? how often? how much would medication help? Given the subjective nature of such issues, it is quite possible to have two medical judgments, both of which are reasonable. And choosing between two reason-

able options is the essence of discretionary judgment. *See Fletcher-Merrit*, 250 F.3d at 1188 (where a "plan administrator offer[ed] a reasonable explanation for its decision, it should not be disturbed even if another reasonable, but different, interpretation may be made" (internal quotation marks omitted); *cf. Consolo*, *supra*, 383 U.S. at 619 ("the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's finding from being supported by substantial evidence").

2. But the plan administrator's decision is, in truth, about more than just which of two or more reasonable doctor's opinions to rely upon. Contrary to the key premise underlying the Ninth Circuit's adoption of the treating physician rule, the decision whether an employee qualifies for disability benefits frequently rests upon just the kind of "complex and hard-to-review mix of considerations" that justify wide deference to the administrator's judgment. *Consolo*, 383 U.S. at 621.

These considerations begin with the language of the plan establishing, *inter alia*, what kind of "disability" an employee must have to receive benefits. In this case, for instance, the Black & Decker Disability Plan defines "disabled," in pertinent part, as "the complete inability (whether physical and/or mental) of a Participant to engage in his regular occupation with the Employer." Pet. App. 3 n.2. Thus, to decide whether a given employee is entitled to benefits under the plan, the plan administrator must evaluate not only "the claimant['s] impairments," *Regula*, 266 F.3d at 1141, but also how those impairments affect his ability to "engage in his regular occupation" with Black & Decker. That decision obviously requires knowledge, perhaps even intimate knowledge, of the employee's job, what it requires, and how it might be changed to accommodate the employee's medical needs. The latter consideration is especially important. In light of the Americans with Disability

Act ("ADA"), employers now have a legal incentive, even the duty, to make reasonable accommodations in an employee's job environment, tasks, schedule, and the like, so as to enable the employee to continue to work despite a disability. 42 U.S.C. §§ 12111(9) & 12112(a)&(b)(5). An employee seeking disability benefits is not obliged to demand a reasonable accommodation under the ADA, to be sure, but neither is an employer barred by ERISA from trying to make reasonable accommodations to a disabled employee to keep him on the job.

In this case the plan administrator *did* engage in exactly the kind of analysis of flexible job requirements one would expect a plan administrator to engage in. It is undisputed that the administrator "discussed" with a Black & Decker human resources professional "the specific duties that were required of [respondent] in his position as a Material Planner and his freedom of movement in that position." Pet. App. 92-93. The administrator determined that respondent "was able to sit or stand at will," and that "help was available" if he needed assistance "lifting any items." *Id.* at 93. The administrator's ultimate denial of benefits was based in part specifically on the administrator's assessment of respondent's "particular job responsibilities." *Id.*

There is of course no evidence in the record that any of respondent's treating physicians engaged in that kind of evaluation of respondent's job requirements. Nor is there any plausible reason any treating physician ever would or could do such an evaluation. Nor is there any reason to think that, if one ever tried, her opinion as a medical doctor about how an employer should alter its job requirements would be of genuine probative value. The need to conduct such assessments is precisely why plan administrators exist, and why employers choose to give them the responsibility and discretion to determine whether a given employee is eligible

for disability benefits. It is also why courts give wide deference to the exercise of that discretion.

3. Finally, to justify applying the treating physician rule when review is for abuse of discretion, a court must presume that the treating physician is so overwhelming likely to have a "better" or "more accurate" opinion about her patient's disability status that no reasonable person would decline to rely on the opinion absent "specific, legitimate reasons" not to. That presumption is unsound. First, as we have just seen, the treating physician is not likely to have much if any knowledge or facility with the requirements of her patient's job. As this case illustrates, she can at best base a determination that her patient has a "complete inability" to engage in her "regular occupation" on a static understanding of certain numerically stated criteria regarding that "regular occupation."

Second, treating physicians are not immune from the kind of conflict that the Ninth Circuit suggested would tend to affect consulting physicians and administrators. The treating physician's sole duty is to her patient; she has no legal duty whatsoever to her patient's employer or other plan beneficiaries. That she would be inclined to support her patient's position in respect to any subjective medical judgments is only to be expected. *See* 63 Fed. Reg. 48390, 48392 (Sept. 9, 1998) ("it is the Department [of Labor]'s view that an individual's attending physician would generally be treated as a representative of the claimant"); *cf. Peabody Coal Co. v. McCandless*, 255 F.3d 465, 469 (7th Cir. 2001) ("Treating physicians often succumb to the temptation to accommodate their patients (and their survivors) at the expense of third parties such as insurers, which implies attaching a discount rather than a preference to their views."); *Stephens v. Heckler*, 755 F.2d 284, 289 (7th Cir. 1985) ("The patient's regular physician may want to do a favor for a friend and client, and so the treating physician may too

quickly find disability."). In view of a treating physician's comparative lack of expertise and potential bias toward her patient, there is no justification for forcing administrators to defer to treating physicians' opinions over other valid evidentiary indicators of a claimant's entitlement to benefits.

4. In sum, the Ninth Circuit's view that the treating physician rule "can assist courts to enforce to accuracy of disability determinations under ERISA," *Regula*, 266 F.3d at 1141, misses the point at every level. The role of the court is *not* to "enforce" the supposed "accuracy" of an administrator's discretionary judgment – it is only to ensure that the administrator has more than a mere scintilla of evidence to support its discretionary decision. Nor does forcing administrators to defer to treating physicians' opinions improve the "accuracy" of benefit determinations in any platonic sense – it only increases the number of claimants who will be deemed qualified under a plan. That result may well be contrary to the best interests of the plan and its other beneficiaries, which is why eligibility determinations are best made not by the application of an unsound presumption, but through the exercise of a fiduciary's discretion.

B. The Treating Physician Rule Should Not Be Invoked As Basis For Discarding Deferential Review Where The Plan Administrator Acts Under A Potential Conflict Of Interest

The treating physician rule makes no more sense as an evidentiary device for uncovering a conflict of interest than it does as a general restriction on the administrator's discretion. The Ninth Circuit held in this case that rejection of the treating physician's interpretation of "disability" proves that the plan administrator was actually influenced by an improper, conflicting interest, thereby warranting *de novo* review. That approach both overestimates the value of the treating physician's opinion and underestimates the likelihood that plan

administrators will act impartially despite potentially conflicting interests.

1. As an initial matter, we believe the Ninth Circuit's general approach to evaluating a potential conflict of interest while simultaneously deferring to the judgment of the potentially conflicted administrator is essentially sound. Even where an administrator *might* be influenced by an improper motive because of the existence of potentially conflicting interests, the Ninth Circuit applies fully deferential review to the administrator's judgment, unless and until the claimant produces "specific facts," beyond the potential conflict itself, demonstrating that the judgment was *actually* influenced by an improper motive. *See Atwood*, *supra*, 45 F.3d at 1322-23; *accord Clapp v. Citibank N.A. Disability Plan*, 262 F.3d 820, 827 (8th Cir. 2001). That approach coheres with the basic trust law analysis of potential conflicts of interest, and resolves practical concerns that courts cannot apply meaningfully deferential review while at the same time assessing the possibility of conflict. *See supra* at 11-12.

Importantly, this approach also recognizes that potential conflicts of interest do not always, or even often, result in decisions that are improperly motivated. ERISA itself reflects the same premise. The statute "provides specifically that employers may appoint their own officers to administer ERISA plans even if the company is a 'party in interest.' 29 U.S.C. § 1108(c)(3)." *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995); *see Pegram v. Herdrich*, 530 U.S. 211, 225 (2000) ("Under ERISA . . . a fiduciary may have financial interests adverse to beneficiaries.") When an employer appoints its own officer or employee to serve as plan administrator, the potential conflict between the employee's incentive to maximize his employer's profits and his responsibilities to plan beneficiaries as administrator is mitigated by ERISA's requirement that the plan administrator discharge his duty as solely in the interest of plan beneficiaries. *See* 29 U.S.C. § 1104(a). This Court has explicitly recognized the efficacy of fiduciary-type professional obligations in tempering conflicting financial incentives in the ERISA context. *See Pegram*, 530 U.S. at 218-19.

In addition, the Department of Labor, pursuant to its regulatory authority to ensure that the claims review process is "full and fair," has issued numerous regulations further protecting claimants from the potentially conflicting interests of plan fiduciaries. The regulations require plans to include "administrative process and safeguards designed to ensure and to verify that benefit claims determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants." 29 C.F.R. § 2560.503-1(b)(5). The regulations assure claimants the right to provide and obtain information, the right to representation in the review process, and the right to an internal appeal. *Id.* §§ 2560.503-1(h)(2)(ii-iv)&(h)(3)(i-ii)&(h)(4). And the Department has specifically provided that, in the internal appeal from a denial of disability benefits that is "based in whole or in part on a medical judgment," the plan administrator must "consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment." *Id.* § 2560.503-1(h)(3). These procedural protections help ensure that claimants receive a fair claim determination, the Department believes, without compromising the "purely voluntary nature" of benefit plan systems. 65 Fed. Reg. 70246, 70246 (Nov. 21, 2000).

Yet another factor mitigating possible conflicts is the employer's longer-term economic interest. Lower courts repeatedly have recognized that it does not make good economic sense for an employer to appoint administrators who "make it a practice of resisting claims for benefits." *Chalmers*, 61 F.3d at 1344. The purpose of a disability

benefit plan "is to please employees, not to result in the employer's bad reputation," *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998), and in the long run a practice of denying claims would only "dampen the loyalties of current employees while hindering attempts to attract new talent," *Chalmers*, 61 F.3d at 1344; *see Nazay v. Miller*, 949 F.3d 1323, 1335 (3d Cir. 1991) (employers have "incentives to avoid the loss of morale and higher wage demands that could result from denials of benefits"); *accord Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996).

All of the foregoing supports the conclusion that where "a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest," *Firestone*, 489 U.S. at 115, the proper way to "weigh" that conflict in determining whether there is an abuse of discretion is to require specific evidence, beyond the mere fact of the potential conflict, showing that the conflict *actually affected* the administrator's exercise of discretion, *see Clapp*, 262 F.3d at 827; *Atwood*, 45 F.3d at 1323. Specific evidence demonstrating such improper influence establishes an abuse of discretion, and it is at that point – but only at that point – that less deferential review is appropriate.

2. The Ninth Circuit, however, now holds that an administrator's mere rejection of a treating physician's opinion, without evidence that the opinion is unreliable, suffices to prove that the administrator was influenced by an improper motive. The evident assumption is that an administrator who decides to follow the opinion of a consulting physician, rather than the treating physician, *must* be improperly motivated, because no reasonable person would ever decline to follow the seemingly reliable opinion of a treating physician in the absence of improper influence. That assumption is entirely baseless.

First, as we have already discussed, the administrator is almost certain to have much more information about the job

requirements than the treating physician, and may believe, in the exercise of his discretion, that the job can be modified to accommodate the employee's medical condition. *See supra* at 16-17. That an administrator would exercise his discretion in that way is not probative of improper influence; to the contrary, it is exactly what one *expects* of an administrator.

Second, the mere fact that the administrator elects "to rely upon the more favorable conclusions of its own examiner," Pet. App. 14, also is not probative evidence of likely improper influence. The court appears to believe that such an inference is warranted because physicians employed by plans to provide independent evaluations "have a clear incentive to make a finding of not disabled in order to save their employers money and to preserve their own consulting arrangements." *Regula*, 266 F.3d at 1143. But the incentive of such physicians is no more powerful than the incentive of the treating physician to preserve an ongoing patient relationship by giving the employer an opinion that pleases the patient, especially when the physician has no duty to the employer. *See supra* at 18-19.

What the court's concern about the financial incentives potentially affecting an administrator's benefit determination overlooks is that *all* the actors in a benefit determination have a variety of different incentives, not all of which point in favor of granting the benefit. Yet both ERISA and this Court's precedent start with the presumption that professionals with fiduciary obligations live up to those obligations, and other incentives work to prevent deviation from those obligations. *See supra* at 20-22. Because of the subjective and complex nature of a disability benefit determination, all those involved – the administrator, the treating physician, the consulting physician, the insurer or other funding source, the claims administration entity – can all discharge their duties faithfully and honestly and still reach different judgments about whether the benefit should be granted. *See supra* at

15-16. That is why most employers make the ultimate decision an act of discretion.

If an administrator relies on the consulting physician's opinion and such reliance is, for whatever reason, unreasonable on its own terms, then there is an abuse of discretion notwithstanding the effect of any potential conflict. But if such reliance appears reasonable, then the court *must defer* to the administrator's choice to rely on the consulting physician, *unless* there is specific evidence showing that the choice to do so was actually driven by an improper motive. What the Ninth Circuit says is that the administrator's decision to rely on the consulting physician proves, in and of itself, that the decision was improperly motivated. That is perfectly circular and perfectly wrong.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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THE BLACK & DECKER DISABILITY PLAN,
Petitioner,

v.

KENNETH L. NORD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF FOR BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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IN THE

Supreme Court of the United States

No. 02-469

THE BLACK & DECKER DISABILITY PLAN,
Petitioner,

v.

KENNETH L. NORD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

INTEREST OF THE AMICUS CURIAE[1]

The Bert Bell/Pete Rozelle NFL Player Retirement Plan ("NFL Player Retirement Plan" or "Plan") benefits present and former National Football League ("NFL") players. The Plan is maintained under collective bargaining agreements between the NFL Management Council ("NFLMC"), the

[1] Pursuant to Rule 37.6, (1) counsel for a party to this case has not authored this brief in whole or in part, and (2) no person or entity other than the *amicus curiae* has made a monetary contribution to the preparation or submission of this brief.

bargaining representative of NFL clubs, and the National Football League Players Association ("NFLPA"), the bargaining representative of NFL players.

The NFL Player Retirement Plan provides disability and pension benefits to eligible players. Vested Players who are unable to work, under the terms of the Plan, receive total and permanent disability benefits until they reach the Plan's normal retirement age of 55. These benefits are paid even if the player's disability is not related to football and even if the player becomes unable to work decades after his NFL career ends. The Plan also provides up to 90 months of payments to eligible players who incur a "substantial disablement" arising out of NFL football, even if they are able to work.

The collective bargaining agreements and the current Plan document reflect decades of care by the NFLMC and the NFLPA to shape these disability benefits. Annual benefits for total and permanent disability currently range from $18,000 to over $224,000. The amount each eligible player receives depends on a variety of factors, such as what caused the disability and how soon after leaving NFL football the player became unable to work. There are special rules and exceptions forged through collective bargaining. For example, players who are unable to work because of alcohol abuse or the use of illegal drugs generally receive a lesser benefit. Because of IRS limits, the NFLMC and the NFLPA have also established a companion plan—the NFL Player Supplemental Disability Plan—that only pays disability benefits in excess of the limits for retirement plans. The NFL Player Retirement Plan makes all eligibility and classification decisions for disability benefits.

In accordance with federal law, the NFL Player Retirement Plan is jointly administered by representatives of its settlors (i.e., the NFLPA and the NFLMC), and has detailed procedures for processing and reviewing benefit claims. A Disability Initial Claims Committee ("Committee") makes

initial decisions on claims for disability benefits. This Committee has two voting members—one appointed by the NFLPA and one appointed by the NFLMC. A player who is dissatisfied in any way with a decision of the Committee may appeal to the Retirement Board. The Retirement Board has six voting members—three appointed by the NFLPA and three appointed by the NFLMC. The members of the Retirement Board serve without pay and average over 20 years each in NFL-related experience, in positions such as a player, coach, agent, or owner.

The Plan maintains a national network of qualified physicians to review each claim for disability benefits. If a player appeals a decision of the Committee, that player is sent to a second physician in this network for a completely independent examination and review. Of course, players are invited to submit any evidence they wish in support of their claim, including reports of their treating physician.

In the 40 years of its existence, the NFL Player Retirement Plan has been sued by many players seeking additional disability benefits. To minimize the cost of this litigation, the Plan's sponsors—the NFLMC and the NFLPA—have deliberately given the Committee and the Retirement Board the broadest possible discretion in deciding claims. Pursuant to this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), decisions of the Retirement Board have been reviewed with deference under the arbitrary and capricious/abuse of discretion standard. Because the NFL Player Retirement Plan is jointly administered by a Retirement Board composed of equal numbers of labor and management members, courts have routinely held that the Retirement Board is not subject to a conflict of interest that might warrant less deferential judicial review. *E.g.*, *Courson v. Bert Bell NFL Player Retirement Plan*, 75 F. Supp.2d 424,

431 (W.D. Pa. 1999), *aff'd*, 214 F.3d 136 (3d Cir. 2000); *see also Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480, 481 (9th Cir. 1990).

The decision below will in many cases eliminate the discretion given to the Committee and the Retirement Board by the Plan's sponsors and settlors—the NFLMC and the NFLPA. The structure intended by these collective bargaining parties will be replaced by a requirement of deference to the views of a treating physician selected by the player. Litigation will increase and different rules will apply in different circuits. The NFL Player Retirement Plan therefore has a keen interest in the issue of whether the treating physician rule applies to ERISA plans.

Both petitioner and respondent have consented to the filing of this brief, and their written consents have been lodged with the Clerk of the Court. The NFL Player Retirement Plan filed a brief *amicus curiae* in *Delta Family-Care Disability and Survivorship Plan v. Regula*, No. 01-1840, addressing the issue that is presented in this case. The Petition for Certiorari in *Regula* is pending.

SUMMARY OF ARGUMENT

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The court of appeals' decisions in this case and in *Regula*, 266 F.3d 1130 (9th Cir. 2001), which were both written by Judge Betty Fletcher, apply a rule developed for Social Security disability benefits to private disability plans voluntarily created by employers. This rule, which is commonly referred to as the "treating physician rule," requires a high degree of deference to the views of the treating physician when deciding whether the claimant is entitled to disability benefits. For example, in the decision below, the Ninth Circuit found that the plan improperly relied on the reports of an independent examining physician and should have instead deferred to the views of the claimant's treating physician. Pet. App. 12-15. The Ninth Circuit thus stripped

The Black & Decker Disability Plan of the deferential review it otherwise would have received and reversed a denial of disability benefits under the *de novo* standard. *Id.*

There is no sound policy or historical basis for this rule. We are unaware of any evidence that treating physicians are less biased or more knowledgeable than independent examining physicians. To the contrary, ethical guidelines of the American Medical Association direct treating physicians to advocate for their patients, and direct independent examining physicians to be objective. Moreover, at its root, the precedent for the rule is hollow. The rule was created by judges years ago in mistaken reliance on earlier cases in which the court had simply found, based on the facts and circumstances, that the views of the treating physician were more persuasive than other evidence in that particular case. Later, faced with inconsistent versions of the rule among the different circuits, the Social Security Administration ("SSA") adopted a single statement of the rule simply to have a national standard.

The treating physician rule violates the statutory and regulatory scheme governing disability plans voluntarily established by employers. Such plans are governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA is based on trust law and allows plan settlors to determine the standards for benefits and whether plan fiduciaries should be able to exercise discretion in deciding claims. ERISA also provides protections for participants and specific procedures for deciding claims. Congress vested the Department of Labor ("DOL") with authority over claims procedures, and DOL has issued detailed rules governing the consideration of disability claims. The Ninth Circuit's adoption of the treating physician rule violates ERISA in several ways:

- In violation of ERISA § 404(a)(1)(D), 29 U.S.C. § 1104 (a)(1)(D), it requires plan trustees and courts to disregard

plan language governing the payment of benefits in favor of the opinions of a treating physician with respect to his patient.

- In violation of ERISA § 503, 29 U.S.C. § 1133, it vests the SSA with *de facto* regulatory authority over ERISA plans. In ERISA § 503, Congress granted the DOL such authority. The decision below is also incompatible with DOL's governing regulation. The DOL's scheme of two levels of review, and two independent medical examinations, is not compatible with the concept that a treating physician's opinion may be controlling.
- In violation of this Court's decision in *Firestone*, it eliminates the ability of a disability plan settlor to give fiduciaries broad discretion in deciding claims.

The decision below will have serious adverse effects on disability plans established by collective bargaining. Collectively bargained plan provisions will be invalidated. Benefit costs will increase if benefits must be paid to persons who are not eligible under the provisions and procedures that the collective bargaining parties intended to apply. These costs may force employers and unions to reduce benefits or terminate plans.

ARGUMENT

I. THE TREATING PHYSICIAN RULE HAS NO POLICY BASIS AND IS BASED ON HOLLOW PRECEDENT.

The treating physician rule is a judicial creation. It has no basis in medical ethics or empirical evidence. Instead, treating physicians have ethical duties to place their patient's welfare above their own self-interest and above obligations to other groups, and to advocate for their patient's welfare. American Medical Association Council on Ethical and Judicial Affairs, Opinion E-10.15 ("The Patient-Physician Relationship"). By contrast, independent medical examiners

whether independent contractors or employees of a business or insurance company, have ethical obligations to evaluate objectively the patient's health or disability, and should not be influenced by the preferences of the patient, employer, or insurance company. American Medical Association Council on Ethical and Judicial Affairs, Opinion E-10.03 ("Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations"). Medical ethics rules thus counsel *against* giving greater weight to treating physician reports.

Nevertheless, in the late 1970s and early 1980s, some circuit courts began to accord "greater weight" to treating physician reports than to independent examining physician reports in Social Security disability cases. *Murray v. Heckler*, 722 F.2d 499, 501-02 (9th Cir. 1983) (Fletcher, J.); *Bowman v. Heckler*, 706 F.2d 564, 568 & n.3 (5th Cir. 1983); *Allen v. Califano*, 613 F.2d 139, 145 (6th Cir. 1980); *Allen v. Weinberger*, 552 F.2d 781, 786 (7th Cir. 1977). In support of this new rule, these cases did not cite any scientific or empirical basis for placing greater weight on treating physician reports. Instead, they cited earlier cases also purporting to accord greater weight to treating physicians generally. For example, in *Murray v. Heckler*, the court cited *McLaughlin v. Secretary of Health, Education and Welfare*, 612 F.2d 701, 705 (2d Cir. 1980), and *Allen v. Califano*; in *Allen v. Califano*, the court cited *Whitson v. Finch*, 437 F.2d 728, 732 (6th Cir. 1971), and *Giddings v. Richardson*, 480 F.2d 652 (6th Cir. 1973).

These foundational cases did not accord "greater weight" to treating physician reports as a general matter. They merely stated that when presented with a treating physician report supporting a grant of Social Security disability benefits, a denial of those benefits must be supported by other substantial evidence in the record. The courts then found that there was insufficient evidence to overcome the particular

treating physician reports in the circumstances of those particular cases. As such, the courts in these cases expressed no preference for treating physician reports over examining physician reports as a general matter.

For example, in *Whitson v. Finch*, the Sixth Circuit was confronted with evidence from two treating physicians that the claimant was unable to work and with an examining physician report that did not appear to address employability. The government denied Social Security disability benefits based on the examining physician's report, and the Sixth Circuit rejected the denial. The Sixth Circuit stated that to rebut the specific findings of the treating physicians as to employability, the government was required to rely on reports that also addressed employability. *See also Gold v. Secretary of Health, Education, and Welfare*, 463 F.2d 38, 42 (2d Cir. 1972); *Teeter v. Flemming*, 270 F.2d 871, 874 (7th Cir. 1959) ("The expert opinion of Dr. Morris as to disability and inability to engage in any substantial, gainful employment, was admissible evidence for consideration by the referee and not, in itself, binding on him. But as it was not controverted by substantial evidence to the contrary, the referee's adverse decision on the ultimate fact was properly set aside.") (cited in *Gold* and *Whitson*).[2]

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[2] The Second Circuit has identified the *Gold* decision as a source of the treating physician rule within that circuit. *Schisler v. Secretary of Health, Education and Welfare*, 3 F.3d 563, 565 (2d Cir. 1993). The *Gold* decision in fact does announce a rule that "'[t]he expert opinions of plaintiff's treating physicians as to plaintiff's disability . . . are binding upon the referee if not controverted by substantial evidence to the contrary. *Teeter v. Flemming*, 7 Cir., 1959, 270 F.2d 871, 77 A.L.R.2d 636. *Kerner v. Flemming*, 2 Cir., 1960, 283 F.2d 916.'" *Gold*, 463 F.2d at 42 (quoting *Walker v. Gardner*, 266 F.Supp. 998, 1002 (S.D. Ind. 1967). But *Gold*, *Kerner*, and *Walker* all involved situations where the evidence that purported to contradict the views of the treating physicians was seen as too insubstantial to justify a denial of benefits. In short, the cited cases simply represent a straightforward application of the substantial evidence test

This history reveals that the precedent for the treating physician rule is hollow. It was created by judges who miscited earlier cases and provided no sound basis for preferring treating physician reports over examining physician reports.

In 1991, SSA adopted a regulation with a single statement of the treating physician rule. SSA did *not* adopt the rule because it found the rule to have any solid empirical basis. Instead, SSA adopted the rule to facilitate uniform national administration. *See* Standards for Consultative Examinations and Existing Medical Evidence, 56 Fed. Reg. 36932, 36934 (1991) ("judicial decisions in several circuits pointed to a need for a clear policy statement that would encourage uniformity of adjudication and provide the public and the courts with a definitive explanation of our policy on weighing treating source opinions. Accordingly, we proposed to replace existing regulations §§ 404.1527 and 416.927 with longer and more detailed provisions that would prescribe rules stating how we would consider and weigh medical opinions. . . . We were guided in the development of these final rules by the general principles articulated by the various circuit courts.").[3]

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rather than the application of a rule granting controlling weight to the opinions of treating physicians. And the Seventh Circuit's decision in *Teeter*, cited in numerous cases as a source of the treating physician rule, in fact rejects the rule.

[3] The regulations that made way for the treating physician rule regulation, former 20 C.F.R. §§ 404.1527 and 416.927 (1989), expressed no presumption in favor of treating physician reports. Former section 404.1527, applicable to the Federal Old-Age, Survivors and Disability Insurance program, stated "We are responsible for determining whether you are disabled. Therefore, a statement by your physician that you are 'disabled' or 'unable to work' does not mean that we will determine that you are disabled. We have to review the medical findings and other evidence that support a physician's statement that you are 'disabled.'" Former section 416.927, applicable to the Supplemental Security Income

Finally, there is absolutely no reason to conclude that the views of a treating physician selected by a claimant will be superior to the views of a physician selected jointly by labor and management fiduciaries of a collectively-bargained plan. The NFL Player Retirement Plan retains only physicians who are believed by both sides to be qualified, experienced, and objective.

II. THE DECISION BELOW VIOLATES ERISA BECAUSE IT STRIPS PLAN SETTLORS OF THEIR ABILITY TO SET STANDARDS FOR DISABILITY DETERMINATIONS.

SSA's treating physician rule pertains to the payment of disability benefits under the federal Social Security program. SSA's rule provides that "[g]enerally, we give more weight to opinions from your treating sources . . . If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight." 20 C.F.R. § 404.1527(d)(2). Courts today rely on the regulation in reviewing SSA disability determinations. *E.g., McGoffin v. Barnhart*, 288 F.3d 1248, 1252 (10th Cir. 2002).

SSA has authority only over the federal Social Security disability program. 42 U.S.C. § 405(a). SSA has no authority over voluntary plans established by private employers, and its rules do not apply to such plans. Voluntary plans are subject to the comprehensive rules of ERISA. The decision below and the decision in *Regula* violate ERISA in several respects.

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for the Aged, Blind, and Disabled program, contained substantially similar language. SSA's grudging acceptance of the treating physician rule thus marked a change from its prior administrative rules.

A. ERISA does not require that an employer establish any disability, health, or retirement plans. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996); *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 443-44 (1999). However, if an employer voluntarily offers employees a plan, the plan's fiduciaries must administer the plan in accordance with the terms of the plan, unless prohibited by ERISA. 29 U.S.C. § 1104(a)(1)(D). ERISA thus codifies a basic principle of trust law regarding trustee responsibility. *See* Restatement (Revised Second) of Trusts § 541 ("A fundamental duty of the trustee is to carry out the directions of the testator or settlor as expressed in the terms of the trust."); *Firestone*, 489 U.S. at 110 ("ERISA abounds with the language and terminology of trust law.").

The decision in *Regula*, which is the basis for the decision below, squarely and improperly rejected the fundamental trust law principle that the specific language of an ERISA plan must be followed when reviewing claims for benefits:

> [I]n the context of a disability claim such as Regula's, the key issue in determining whether a claimant is entitled to benefits is not the language of the plan, but the facts of the particular case. Hence, just as in Social Security cases, the issue in dispute in this case is not the meaning of the terms of the plan but whether the facts of Regula's case entitle[d] him to benefits.

Regula, 266 F.3d at 1141. *Regula* and the decision below violate ERISA's fundamental directive that trustees must follow plan language unless otherwise directed by ERISA. These decisions improperly impose on plan administrators and courts a particular method of weighing the evidence in the plan administrative record. This method may cause an award of benefits regardless of the terms of the plan.

B. Congress has authorized the DOL, not the SSA, to set standards for processing claims under ERISA plans. 29 U.S.C. § 1133. No DOL regulation or other authority has

ever imposed any form of a treating physician rule on voluntary disability plans subject to ERISA. The DOL recently issued elaborate procedures for handling disability claims under ERISA. 29 C.F.R. § 2560.503-1. The treating physician rule is incompatible with the DOL's claims regulation in several ways:

- Paragraph (b)(5) of the DOL regulation requires that plan claims procedures contain safeguards to ensure that decisions are consistent with plan documents and that plan provisions are consistently applied. The treating physician rule flies in the face of this provision. Indeed, plan provisions will not even be consulted and will be applied differently in cases that are factually indistinguishable because of differences in opinions between treating physicians.
- Paragraph (h)(ii) of the DOL regulation provides that the named fiduciary handling an appeal from an adverse benefit determination may not defer to the initial claims decision. But if the initial claims decisionmaker must defer to the treating physician, then it follows that the named fiduciary handling the appeal must defer to the initial determination.
- Paragraph (h)(iii) of the DOL regulation requires the named fiduciary on appeal to consult with an independent medical professional who is different from, and not subordinate to, the medical professional that was consulted at the initial claims stage. It would be senseless to compel the fiduciary to consult with an independent medical professional if that same fiduciary must effectively ignore that professional's advice and defer to the treating physician.

The decision below also is in direct conflict with Congress' directive to place the DOL in charge of the procedures for processing claims for ERISA benefits. Simply put, the decision below makes SSA an ERISA regulator. SSA may change, withdraw, or expand the treating physician rule, thereby changing the terms of ERISA disability plans without

consideration of the needs of ERISA plans. But Congress nowhere gave SSA such authority with respect to ERISA plans voluntarily established by private employers. *See Leahy v. Raytheon Co.*, 315 F.3d 11, 20 (1st Cir. 2002) (describing why "[t]he calculus of decision in social security cases differs significantly from that employed in ERISA cases").

C. The decision below is contrary to this Court's decision in *Firestone*. In that case this Court determined that plan settlors may grant their designated trustees discretion to interpret plans and decide benefits, and that the general standard of judicial review where such discretion has been granted is the arbitrary and capricous/abuse of discretion standard. 489 U.S. at 115. *Firestone* is also based on the trust principle that a plan settlor may establish binding plan terms.

The decision below squarely holds that, even where the plan settlor explicitly gives the trustees discretion to decide claims, that discretion must be turned over to the treating physician. Indeed, if properly documented, the treating physician's views may be "controlling." 20 C.F.R. § 404.1527(d)(2). The decision below cannot be reconciled with this Court's decision in *Firestone*.

III. THE DECISION BELOW STRIKES COLLECTIVELY-BARGAINED PLAN PROVISIONS AND INCREASES THE COSTS OF DISABILITY PLANS.

The decision below extends the treating physician rule to all ERISA plans, including collectively-bargained plans like the NFL Player Retirement Plan, that provide disability benefits. The Ninth Circuit's sweeping decision will have far-ranging effects on collectively-bargained disability benefits in particular, and on ERISA disability benefit plans in general.

The collective bargaining parties and settlors of the NFL Player Retirement Plan—the NFLPA and the NFLMC—have over decades very carefully and methodically developed detailed rules and generous provisions for the payment of disability benefits to eligible players. There are rules regarding when a player is unable to work. For example, payments by an NFL club or a charitable organization may be disregarded in determining whether a player is capable of gainful employment. There are rules as to when a disability arises from NFL football and thus entitles the player to a higher level of benefits. There are rules that provide higher benefits to a player who is unable to work shortly after his NFL career ends. There are rules that reduce benefits in some cases where a disability arises from abuse of alcohol or illegal drugs.

It is not, and never was, the intent of the NFLPA and the NFLMC to allow treating physicians to determine how these rules apply to players. The settlors of the NFL Player Retirement Plan intend that these decisions will be made by the Committee and the Retirement Board. The members of the Committee and the Retirement Board have extensive experience in reviewing claims. The NFLPA and the NFLMC have established a dispute resolution mechanism in which deadlocks with respect to a player's medical condition are resolved by a Medical Advisory Physician ("MAP") jointly appointed by management and labor. Under the terms of the Plan, a MAP's medical determination is final and binding on the Retirement Board. The treating physician rule renders the MAP mechanism ineffective, because it would set aside MAP determinations that are different from a treating physician's determinations.

Industry-specific disability rules developed over time in light of experience are not unique to the NFL Player Retirement Plan. Other plans covering employees in other industries have similar specialized rules. For example, the

collectively-bargained plan covering tens of thousands of bituminous coal miners provides disability benefits only to miners who become "totally disabled as a result of a mine accident," and the trustees of the plan have adopted detailed interpretative rules explaining how this standard is applied. *Brogan v. Holland*, 105 F.3d 158, 162 (4th Cir. 1997).

If the treating physician rule is superimposed upon these types of specially developed, industry-specific disability rules, the outcomes may bear little resemblance to the expectations of the collective bargaining parties. In *Brogan*, for example, two treating physicians opined that the claimant's disabling stroke occurred while he was on the job. Four examining physicians concluded that the stroke had occurred while he was at home. The court affirmed the trustees' decision to deny the claim based on their assessment of all the evidence in a manner consistent with their established interpretations of the plan standard. *Id.* at 162-63. If the court had applied the treating physician rule, the outcome may well have been different.

Twenty years ago, the Court restrained the tendency of the lower courts to rewrite the terms of collectively-bargained employee benefit plans to satisfy courts' idiosyncratic notions of the proper rules that should govern the award of benefits. *United Mine Workers of America Health and Retirement Funds v. Robinson*, 455 U.S. 562 (1982). As the Court then said, "when neither the collective-bargaining process nor its end product violates any command of Congress, a federal court has no authority to modify the substantive terms of a collective-bargaining contract." *Id.* at 576.

The Ninth Circuit's imposition of the treating physician rule onto all ERISA plans, whether established by collective bargaining or by unilateral employer decision, plainly undercuts the rule articulated in *Robinson*. As the Court has acknowledged, both collectively-bargained plans and non-bargained, employer-sponsored plans are free to set their

terms in any manner the parties choose, subject only to the constraints that Congress affirmatively has imposed by statute. *Id.* at 575 ("The terms of any collective-bargaining agreement must comply with federal laws that prohibit discrimination on grounds of race, color, religion, sex, or national origin; that protect veterans; that regulate certain industries; and that preserve our competitive economy.") (footnotes omitted); *Curtiss-Wright*, 514 U.S. at 78 ("[W]e are mindful that ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.")

The Ninth Circuit's decision to engraft the treating physician rule onto all employee welfare benefit plans that provide disability benefits produces a result fundamentally at odds both with the intentions of Congress when it adopted ERISA and with the rulings of the Court recognizing that these private welfare arrangements are best left to employees and employers who must decide what resources should be allocated to employee benefits and what rules should govern the award of such benefits.

All disability plans, not just collectively-bargained plans, will experience adverse effects from the treating physician rule. All disability plans may be required to pay disability benefits to unintended claimants, and plan settlors may elect to either reduce future disability benefits or decline to improve future benefits. The Ninth Circuit's decision will thus have the unintended consequence of reducing benefits for all qualified claimants.

CONCLUSION

The decision of the court of appeals below should be reversed.

Respectfully submitted,

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THE BLACK & DECKER DISABILITY PLAN,

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KENNETH C. NORD,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

BRIEF AMICI CURIAE ON BEHALF OF PEABODY ENERGY CORPORATION, OLD REPUBLIC INSURANCE COMPANY AND SIGNAL MUTUAL INDEMNITY ASSOCIATION, LTD. IN SUPPORT OF PETITIONER

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INTEREST OF AMICI[1]

Peabody Energy Corporation ("Peabody") is the largest investor-owned coal producer in the world, providing coal for the generation of 9% of all electricity produced in the United States in 2001, and 2.5% of all electricity produced in the world for that year. Peabody owns and operates coal mines in nine states, including states within the jurisdiction of the Fourth, Sixth, Seventh and Ninth Circuits. Many of Peabody's 6,500 employees participate in employee benefit plans subject to the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461 ("ERISA"). Like petitioner Black & Decker, Peabody now is subject to inconsistent rules for establishing the appropriate weight to be accorded treating doctors in disability claims submitted under company-sponsored employee benefit plans.

Many of Peabody's employees are employed in the production and transportation of coal. Peabody and its coal production employees are subject to the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("BLBA") and some employees are covered under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §§ 901-950 ("LHWCA"). Peabody has filed two petitions for a writ of certiorari to challenge the Sixth Circuit's treating doctor preference or presumption in black lung benefit claims. *Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3154 (Aug. 17, 2002) (U.S. No. 02-249), *petition for reh. filed*; *Gray v. Peabody*

[1] Counsel for amici are the sole authors of this brief. Amici are the sole contributors to the cost of this brief. The parties' written consent to file this brief have been submitted to the Court.

Coal Co., 35 Fed. Appx. 138 (6th Cir. 2002) (unpublished), *petition for cert. filed*, 71 U.S.L.W. 3319 (U.S. Oct. 17, 2002) (No. 02-585).

Peabody also pays tens of millions of dollars annually into the Black Lung Disability Trust Fund. *See* 26 U.S.C. § 4121. This Trust Fund pays benefits in black lung claims for which no mine operator or insurer is directly liable under the BLBA. 30 U.S.C. § 934. The substantial relaxation of benefit eligibility criteria attributable to a treating doctor rule increases Peabody's liability to the Trust Fund over time and eventually will extend the life of the excise tax that funds the Trust for an unknown but significant period of years. *See* 26 U.S.C. §§ 4121, 9501.

The Old Republic Insurance Company ("Old Republic"), a subsidiary of the Old Republic International Corporation, is a commercial insurance carrier licensed in most coal mining states to insure the workers' compensation liability of mine operators under the BLBA. For many years, Old Republic was the principal servicing carrier for the National Worker's Compensation Reinsurance Pool and various states' residual market pools in coal mining states allowing private workers' compensation insurance. Old Republic has received over 35,000 federal black lung claims since 1974, as a direct insurer, residual market servicing carrier and third party administrator. Thousands of previously filed claims remain active and thousands more are anticipated in coming years. Old Republic also is co-petitioner in *Jericol Mining, Inc. v. Napier*, 301 F.3d 703 (6th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3401 (U.S. Nov. 27, 2002) (No. 02-834), a case that challenges the Sixth Circuit's treating doctor rule for black lung claims. Hundreds of other pending cases surely will

involve a determination by the adjudicator whether to rely on a treating doctor preference.

Signal Mutual Indemnity Association Limited is a not-for-profit group self-insurance facility authorized by the U.S. Secretary of Labor to secure benefits payable to workers and their families under the LHWCA, and its extensions. Signal's members include over 200 employers subject to the LHWCA, including stevedores, terminal operators, shipbuilders, ship and container repairers, offshore drilling and marine construction companies.

The LHWCA establishes the general rules of evidence and procedure for the adjudication of both LHWCA and BLBA claims. 33 U.S.C. §§ 919-21, *incorporated by reference into* 30 U.S.C. § 932(a).

INTRODUCTION AND SUMMARY OF ARGUMENT

There is no good and valid treating doctor rule which adds evidentiary weight for the doctor's status. Parties to disputes, however they are judged, universally expect that equal standards will apply to all proof and that conflicts in that proof will be resolved for good and fair reasons. Our system of justice, in part, earns the confidence and respect of the people who call upon it by meeting those expectations. A system that perpetuates demonstrably false rules, rules that divert attention from the truth-seeking function of the adjudication, and rules that we all know cheat the truth are unacceptable. Treating doctor rules, in whatever form they take, always cheat the truth.

A treating doctor rule may be dressed up in "criteria" like SSA's rules[2] and the Department of Labor's ("DOL") black lung regulations,[3] or it may reflect a simple *per se* preference like the Ninth Circuit's ERISA rule under review here. In either case, there is no doubt about the purpose of the rule. Its purpose is to enhance the weight of a treating doctor's opinion when that opinion or testimony does not merit more weight because it is more persuasive, better reasoned and best documented by medical data. Its principal purpose is to accord weight because of the doctor's status as the treating physician. The principal consequence of applying a treating doctor rule is to downgrade better evidence.

All treating doctor rules are predicated on a judicial belief that treating doctors, even in this age of modern technology, gain special insight and enhanced powers of understanding by having treated a patient. If that belief were true and a physician's report or testimony reflected superior understanding that withstood cross-examination, then the treating doctor's opinion would merit the most weight whether or not a treating doctor preference was in force. The rule applies, therefore, only when the treating doctor's opinion is undermined by other relevant evidence and it works its magic by elevating evidence of lesser persuasion. It is not surprising that litigants on the losing end of any dispute decided because of a treating doctor preference feel unfairly prejudice.

[2] 20 C.F.R. §§ 404.1527(d), 416.927(d).

[3] 20 C.F.R. § 718.104(d).

A rule with the power to control the outcome of large numbers of adjudications that is predicated on scientific or medical assumptions must have those assumptions tested before the rule is approved. If the rule fails the test, this Court's precedents preclude its use. The treating doctor rule is not supported by good or any science. It is a pernicious, outcome-determinative rule that exaggerates the significance of certain proof without any valid foundation. It undermines the adjudicator's gatekeeper function and casts doubt on the integrity of the adjudication in which the rule is invoked. It defies ordinary appellate review.

No treating physician rule should survive review by this Court.

ARGUMENT

1. A Treating Physician Rule Is Scientifically Unsupported

In *Teeter v. Flemming*, 270 F.2d 871, 874-5 (7th Cir. 1959), the Seventh Circuit reached the unremarkable conclusion that an SSA disability benefit applicant's treating physician's report is admissible evidence and where uncontroverted, should be credited. This seems to be the origin of the treating physician rule. A few years later, an Indiana federal district court added a new word to the *Teeter* rule. The Indiana court held that the treating physician's report was "binding" if not controverted. *Walker v. Gardner*, 266 F.Supp. 998, 1002 (S.D. Ind. 1967). Neither case engages in a discussion of the significance of being a treating doctor and in both cases, the focus is on the presence of uncontradicted medical evidence, not on

the treating doctor status of the witness offering the opinion.

Relying on *Teeter* and *Walker*, the Second Circuit almost unintentionally launched a true treating doctor preference in *Gold v. Sec'y of Health, Ed. & Welfare*, 463 F.2d 38, 42 (2d Cir. 1972). Minnie Gold was a Holocaust survivor who never made more than $1,403 annually. During her years in hiding from Nazi occupation, she contracted tuberculosis. After a life of hardship and struggle, her earlier affliction led to a disabling lung disease. SSA denied her claim and the district court upheld the denial. The Second Circuit reversed, citing *Teeter* and *Walker*, and held that supportive treating physicians' reports addressing a patient's disability are "binding if not controverted by substantial evidence to the contrary." *Id.* That the supportive evidence was supplied by treating doctors seem coincidental.

Although the Seventh Circuit later repudiated its so-called treating doctor rule in *Cummins v. Schweiker,* 670 F.2d 81 (7th Cir. 1982), the Second Circuit embraced a powerful version of the rule. *See Schisler v. Bowen*, 851 F.2d 43, 47 (2d Cir. 1988). Later, a rationale for the rule was supplied. In upholding SSA's somewhat more modest regulations, the Second Circuit accorded deference to the agency rule in substitution for the circuit rule because it "continue[s] to give deference to the opinion of treating physicians based on the view that opinions based on a patient-physician relationship are more reliable than opinions based, say, solely on an examination for purposes of the disability proceedings themselves."

Schisler v. Sullivan, 3 F.3d 563, 568 (2d Cir. 1993). The source of the conclusion is not revealed.[4] Other reasons in support of the rule emerged over time. The Ninth Circuit observed "that deference to the opinion of the claimant's treating physician [is proper] because 'he is employed to cure and has greater opportunity to know and observe the patient as an individual.'" *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1140 (9th Cir. 2001), *petition for cert. filed*, 71 U.S.L.W. 3001 (U.S. No. 01-1840), *quoting Morgan v. Comm'r, SSA*, 169 F.3d 595, 600 (9th Cir. 1999).

In *Regula*, the Ninth Circuit applied the SSA rule to ERISA claims, reasoning that both were federally based disability programs and uniform standards made sense. *Regula*, 266 F.3d at 1140.[5] *Regula* does not test the validity of the treating doctor rule or clearly specify whether the Court is adopting the SSA regulation or the Second Circuit's "controlling weight" rule or something else. The court believed, simply, that in addition to the virtues of consistency, "common sense" supported the treating doctor preference. *Regula*, 266 F.3d at 1139.

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[4] It is likely that the SSA regulation was motivated mostly by that agency's unwillingness to accept the Second Circuit's powerful treating doctor rule, and not to reflect any medically justified improvement in SSA's eligibility criteria.

[5] The circuits that have refused to import the SSA treating physician rule into ERISA cases are fairly dismissive in their reasoning and do not directly challenge the notions articulated in *Regula*. *See e.g., Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002); *Connors v. Connecticut Gen. Life Ins. Co.*, 272 F.3d 127, 136 n.4 (2d Cir. 2001); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-8 (4th Cir. 1999).

The Sixth Circuit then followed *Regula*, relying also on a recent black lung benefit decision and the premise that the treating doctor's knowledge and observation of the patient warrant deference. *Darland v. Fortis Benefits Insurance Co.*, 317 F.3d 516 (6th Cir. 2003) (*citing Peabody Coal Co. v. Groves*, 277 F.3d at 833-35).[6] The Sixth Circuit's first decision mandating a treating doctor rule for black lung claims relies on SSA's rule. *See Tussey v. Island Creek Coal Co.*, 982 F.2d 1036 (6th Cir. 1993) (citing SSA cases as authority for holding "it is clearly established that opinions of treating physicians are entitled to greater weight. . . . "). The Sixth Circuit looks also to DOL's new treating doctor regulation for guidance, whether or not the regulation applies to the particular case. *Groves*, 277 F.3d at 837. It is not clear whether the Sixth Circuit now intends to apply the SSA rule or the black lung rule or

[6] The Sixth Circuit black lung rule is a preference guided by DOL's new regulation roughly approximating the SSA regulation. Under DOL's regulation, the treating doctor's opinion is controlling not only with respect to the extent of disability, which might be enhanced by personal observation, but also with respect to diagnosis, determination of cause of death and occupational causation, none of which are even arguably enhanced by personal observation. *See e.g.*, *Wolf Creek Collieries v. Director, OWCP*, 298 F.3d 511 (6th Cir. 2002) (cause of death), *Groves*, 277 F.3d 829 (diagnosis of occupational disease). The DOL regulation directs the factfinder to consider the nature of the relationship, the duration of the relationship, the frequency of treatment, the extent of treatment and, lastly, the credibility of the physician's opinion. 20 C.F.R. § 718.104(d). The rule offers no guidance on how to apply the criteria or what weight each carries but it also provides that the treating doctor's status, *i.e.*, "the relationship between the miner and his physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight." *Id.* § 718.104(d)(5).

whether the court considers the two rules to be sufficiently similar that it is unnecessary to distinguish them.

As is the case in ERISA matters, several courts of appeals reject the Department of Labor's treating doctor preference. *Consolidation Coal Co. v. Held*, 314 F.3d 184, 187-88 (4th Cir. 2002) (rejecting the premise that a treating doctor's status merits special weight); *Peabody Coal Co. v. McCandless*, 255 F.3d 465, 469-70 (7th Cir. 2001) (holding that an ALJ must have a valid medical reason for according extra weight to a treating doctor's opinion).

The legacy of Minnie Gold, who surely deserved benefits and whose best evidence was only coincidentally supplied by treating doctors as well as others, is a fog of rules that provide little or no guidance to anyone. The rules now are more a result orientation[7] than they are sound and valid guidelines for adjudication. The one question that neither the Ninth Circuit, nor the Sixth Circuit, nor the Second Circuit seems concerned with is whether there is a valid medical rationale for any treating doctor preference. These courts are satisfied simply to accept their own medical judgments as sufficient. No

[7] The Sixth Circuit's decision in *Napier* is instructive. There, the Court held that the ALJ had no valid reason to give more credit to the treating doctor, but then affirmed an award of benefits, finding that the ALJ's decision was supported by substantial evidence. In this sleight of hand, the court simply ignores the fact that the ALJ resolved the medical questions in the case principally on the basis of a strong treating doctor preference. *See Napier*, Petition for Cert. at App. 36, 65. Both DOL and the Sixth Circuit seem inclined to enforce a *per se* treating doctor rule while denying having done so. The court's decision in *Gray*, which demands greater weight because of the treating doctor's status, is incompatible with the Sixth Circuit's denial that its rule is very strong indeed. *See Gray*, Petition for Cert. at App. 5-7.

medical authority is cited in any case, nor do any of the treating doctors in the cases claim to have enhanced insight that goes beyond the reasoning and documentation in their reports.

Congress has not adopted or, as far as amici have found, held hearings on a proposed treating doctor rule. It seems also that SSA adopted its rule mostly to eliminate the Second Circuit's rule which SSA apparently considered unacceptable.

The only search for a validating scientific principle occurred in DOL's black lung rulemaking from 1997-2001, and that exercise proves fairly conclusively that treating doctors do not have sufficient enhanced insight to warrant presuming its existence as a matter of course.

In response to DOL's specific request for assistance in designing a treating doctor rule, 64 Fed. Reg. 54919 (Oct. 8, 1999), the public comments on the rulemaking from the medical community uniformly opposed any rule.

The American College of Chest Physicians commented:

> We agree that some opinions should be considered to carry more weight than others. Opinions that carry the most weight should be based on the competence of the physicians and the competence of the opinion that was written. Everything else (the duration of the relationship between the doctor and the miner or the extent of the treatments) is irrelevant. This is an important error in the proposed regulations which must be corrected in the amended version of the black lung regulations.

Exhibit 5-165 to Proposed Rulemaking ("Comments on Proposed Rule: Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended" by Daniel E. Banks, M.D., FCCP, *et al.*, representing the American College of Chest Physicians Section on Occupational and Environmental Health (Aug. 20, 1997)). The Occupational Lung Disorder Committee of the American College of Occupational and Environmental Medicine opposed the preference:

> The Committee recognizes that the treating physicians can provide important insight and medical information when rendering an opinion in regard to pulmonary disease related to coal mine dust exposure. The treating physician, however, has an inherent conflict of interest in determining whether the coal miner patient is totally disabled from pneumoconiosis due to coal mine dust exposure. By supporting their patient's claim for black lung benefits, the treating physician is helping to guarantee future reimbursement for medical services rendered by the treating physician for almost any type of pulmonary disorder in ensuing years based on the proposed amendments to the Black Lung Benefits Act. This represents a direct financial conflict of interests. The eligibility determination for Black Lung Benefits should be done as independent medical evaluations by physicians with extensive experience and training in occupational pulmonary disease. The treating physician's medical records and supportive documentation should be available for review by the independent medical examiners and taken under consideration when rendering their opinions. The treating physician's opinion can be counted as a pulmonary evaluation but should be given equal and not

> controlling weight in determining whether a coal miner is totally disabled or died due to pneumoconiosis.

Exhibit 5-166 to Proposed Rulemaking (Comments of the American College of Occupational and Environmental Medicine, Occupational Lung Disorder Committee regarding the DOL Proposal to Amend Regulations Implementing the Black Lung Benefits Act (Aug. 21, 1997)).

Drs. Ben Branscomb and William Bailey, both distinguished professors of pulmonary medicine at the University of Alabama at Birmingham, opposed any treating doctor preference:

> We feel it is bad science to impose upon the adjudicator regulations that mandate giving contr l-ling weight to the treating physician. In everyda.' practice, physicians evaluate numerous medical reports and weigh different physicians' opinions depending on *the question that is being asked and the scientific quality of the answer.* We see no reason why medical questions for coal miners should be adjudicated differently.

Exhibit 5-174: App. 8 at 13-14, Comments of the National Mining Assn., *et al.* (Aug. 21, 1997). Dr. Branscomb further testified:

> . . . I think that to assign particular weight to someone called the treating physician is artificial and is going to interfere with the objectives of the department in getting the right information out. . . . [T]he doctor's opinion ought to stand on itself, not on some designation that he's a treating physician.
>
> * * *

> And I think it is contrived and contrary to good practice to artificially assign a special weight to the treating physician.

Exhibit 35 (Branscomb Tr. at 42, 43). Dr. Greg Fino, a board-certified pulmonologist with extensive experience in examining and treating miners, testified:

> The Department's proposal to give opinions from treating doctors "controlling" weight is a departure from sound medical practice. The medical evaluation of coal miners is no different than the evaluation of any other patient with respiratory or pulmonary symptoms or complaints. Doctors do not evaluate medical reports or opinions based on the status of the doctor, they weigh different opinions based on the question that is at issue and the underlying support both in the science and in the studies conducted. There simply is no scientific support for the Department's proposal that treating doctors are in a better position to diagnose pneumoconiosis or determine both the extent and cause of a patient's impairment.
>
> * * *
>
> Frequent contact alone provides no advantage. The mere fact of treatment of a miner's general health is medically irrelevant if the doctor does not have the basic skills or has not performed the relevant tests. The quality of an opinion by a treating doctor, an examining doctor, or a consultant on questions of impairment depends on the special training, skill, and expertise of the doctor and the availability of objective tests of lung function that can be validated according to published standards by a qualified pulmonary physician. . . . There is no medical rationale to automatically give more weight to a treating

physician in the evaluation of a miner's pulmonary status.

Exhibit 89-37: App. C (Greg Fino, *et al.*, "Comments on the Medical and Scientific Issues Presented in the Department of Labor's Proposal dated October 8, 1999").

The National Institute for Occupational Safety and Health, DOL's statutory medical advisor for black lung benefit eligibility criteria, *see* 30 U.S.C. § 902(f)(1)(D), was solicited for its comments on the DOL regulation and simply did not mention the treating doctor rule. *See* Exh. Nos. 72 and 5-173 to Proposed Rulemaking. No medical authority supported the rule.

Notwithstanding DOL's failure to generate any supportive evidence for the rule, the agency adopted it anyway, noting: "The rule's purpose is to recognize that a physician's professional relationship with the miner may enhance his insight into the miner's pulmonary condition. A treating physician may develop a more in-depth knowledge and understanding of the miner's respiratory and pulmonary condition than a physician who examines the miner only once or who reviews others' examination reports." 65 Fed. Reg. 79923 (Dec. 20, 2000). DOL, like the Ninth Circuit, is committed to this rationale whether or not it is a generally accepted medical view or accepted by any reasonable medical authority.

There is not a scintilla of support for this rationale in the rulemaking record.[8] There is not much doubt that a

[8] The D.C. Circuit held that DOL needed no record to support the rule, treating it as a pure policy judgment entrusted to the agency. *National Mining Assn. v. DOL*, 292 F.3d 849, 870-71 (D.C. Cir. 2002).

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treating physician rule is simply a cheater's rule. Its only function is to change the outcome where the evidence fails to prove one side's case.[9] This is not reasoned decisionmaking and it is not compatible with any proper expectation of fair adjudication.

While these amici curiae are concerned principally with the use of a treating doctor rule in black lung and longshore claims, neither is the rule appropriate for application in ERISA claims. In all cases, this rule, in whatever form, fails the test of elementary justice and it should be struck down for this important reason.

2. A Treating Physician Rule Violates Important Legal Principles

Bad science makes bad law and when courts embrace bad science or any demonstrably bad rule, the interests of justice are diminished. This Court repeatedly has rejected questionable, overbroad and unsubstantiated rules that impair the truth-seeking process. Although the Federal Rules of Evidence do not apply in most administrative adjudications, including ERISA, longshore and black lung disability claims, the principles articulated in *Daubert v.*

Employers continue to challenge the rule on the grounds that the adoption of a rule of science is not a policy judgment left to an agency, but must be supported.

[9] In the black lung rulemaking, DOL noted in Preamble commentary that one purpose of the treating doctor rule was to override this Court's decision in *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), striking down the "true doubt" rule on the grounds that it violated section *1*(c) of the Administrative Procedure Act, 5 U.S.C. § 556(d). 65 Fed. Reg. 79926 (Dec. 20, 1999).

Merrill Dow Pharmaceutical, 509 U.S. 579 (1993), and its progeny are no less valid for administrative litigants. Administrative judges and benefit plan administrators may not preside over factfinding by a jury, but should nonetheless impose upon themselves the same gatekeeping responsibilities that are expected of federal trial judges. *See McCandless*, 255 F.3d at 468-69 ("*Daubert* does not apply directly in black lung cases. . . . Agencies relax the rules of evidence because they believe that they have the skill necessary to handle evidence that might mislead a jury. . . . They have a corresponding obligation to use that skill when evaluating technical evidence."); *United States Steel Mining Co., Inc. v. Director, OWCP*, 187 F.3d 384, 388-89 (4th Cir. 1999) (holding that in an APA proceeding, "the agency process . . . requires that the ALJ perform a gatekeeping function while assessing evidence. . . . "); *see also* Miller, *et al.*, " 'Gatekeeping' Agency Reliance On Scientific and Technical Materials After Daubert: Ensuring Relevance and Reliability in the Administrative Process," 17 *Touro L. Rev.* 297 (2000).

All the treating doctor rules distort the focus in the factfinding process and suggest that treating doctor's opinions are immune from the scrutiny that all adjudicators are expected to impose on all other kinds of evidence. *See Canavan's Case*, 432 Mass. 304, 313-14, 733 N.E.2d 1042 (Mass. 2000). "There is no logical reason" to support a special exception to the normal rules ensuring the reliability of medical evidence simply because a doctor treated or personally observed a patient. *Id.*

In the absence of any medical support for a treating physician preference or general acceptance by physicians that the treating relationship enhances insight, and in the presence of fairly uniform denials[10] of the medical validity of the rule, the reliance by the Ninth Circuit and DOL in its black lung rules on notions of "common sense" and a presumption of enhanced "insight" is not credible at all or even arguably valid.

The rule distorts the weight of evidence for no good reason, exaggerating the significance of one kind of evidence that does not deserve to be so elevated. This is not permitted under the APA and it should not be condoned in ERISA claims determinations. *See Allentown Mack Sales & Serv., Inc. v. NLRB*, 522 U.S. 359, 377-78 (1998). It is a categorical rule that not only fails to hold true in a majority of cases, it probably rarely, if ever, is true to the extent that status alone is worthy of extra weight. This Court disapproves categorical or *per se* rules without an "empirical" or "logical" basis and the treating doctor rule fits well

[10] Amici have found nothing in medical literature to support the rule. Many commentators criticize it. *See e.g.*, Davis and Pierce, *Administrative Law Treatise* § 11.3 (3d ed. 1994); Prentice, "The SEC and MDP: Implications of the Self-Serving Bias for Independent Auditing", 61 *Ohio St. Law J.* 1597, 1621-22 (2000); Noah, "Pigeonholing Illness: Medical Diagnosis as a Legal Construct," 50 *Hastings Law J.* 241, 242-43, 296 (1999); Foley, "Physician Advocacy and Doctor Deception," 48 *The Fed. Lawyer* 25 (2001); Freeman, *et al.*, "Lying for Patients: Physician Deception of Third Party Payers," 159 *Arch. of Internal Med.* 2203 (1999); Sage, "Physicians as Advocates", 35 *Hous. L. Rev.* 1529 (1999); Schneider, "A Role for the Courts: Treating Physician Evidence in Social Security Determinations," 3 *U. Chi. L. Sch. Roundtable* 391, 412-13 (1996).

inside the prohibited territory. *See Ragsdale v. Wolverine World Wide, Inc.*, 535 U.S. 81, 122 S.Ct. at 1162 (2002).

The Ninth Circuit's ERISA rule, like all the other treating doctor rules, hides behind a false rationale and serves only to give more weight to proof that is not good enough standing on its own. Rules like this deny parties their expectation of reasoned and fair decisionmaking and they should be soundly repudiated by this Court.

3. A Treating Physician Rule Spreads Adverse Consequences In Many Directions

The California experience with a treating doctor rule is instructive. A treating doctor presumption was adopted in 1993, by California for its workers' compensation system. The rule shifted the burden of persuasion on levels of disability by presuming the correctness of the treating doctor's opinion. *See Minniear v. Mt. San Antonio Comm. College Dist.*, 61 Cal. Comp. Cases 1055 (Cal. W.C.A.B. September 1996) (recon. denied). *Minniear* expanded the rule to include treatment decisions as well as disability determinations and through judicial decision, the treating doctor's opinion "on all medical issues was nearly irrebuttable, making it almost impossible for claims administrators to terminate unreasonable, unnecessary, excessive or incompetent care." Gardner and Swedlow, "California Workers' Compensation Medical Payments, Litigation and Claim Duration – A Post-Reform Report Card," *California Compensation Institute Research Notes* (May 2002) ("the California Study").

The huge financial impact on California employers of the California rule caused a legislative review of it. The California Study proved that the rule caused significant

increases in claims litigation rates, the duration of claims, treatment costs, total claims costs, medical-legal costs and claim frequency. California Study at 7. Legislation to significantly limit California's rule was adopted in February 2002. *See* Cal. Assembly Bill 749, Legislative Counsel's Digest § 18 (2002).

Commentators from a variety of disciplines have bad things to say about a treating doctor rule – that it adversely affects therapeutic decisionmaking, leads to improper or overtreatment of patients, that it creates unnecessary conflicts between doctors and patients and encourages physician dishonesty. It increases health care costs and the volume of litigation in the programs that adopt such a rule. *See supra* at 17, n.10. For the black lung program, actuaries reported that the rule would have an impact on most elements of a decision whether or not to award benefits and robs the system of predictability and insurability, at great and inappropriate cost to industry.[11] For these amici, the workers' compensation impact of a

[11] In the black lung rulemaking, Robert Briscoe, an actuary who specializes in black lung insurance and has served as a consultant to the Commonwealth of Kentucky and the National Council on Compensation Insurance ("NCCI"), a not-for-profit state licensed, worker's compensation insurance rating organization that assesses the cost of legislative or regulatory changes among other things, submitted several estimates of the consequences of DOL's new rules. Briscoe and NCCI pointed out that DOL's treating doctor rule was among the most costly of DOL's regulations and that the consequences of these rules as a whole would be a loss of up to 25,000 coal mining jobs and the insolvency of almost 1,000 small mine operators. DOL Rulemaking Record at Exh. 5-174 at Ex. 5; Exh. 89-37 at App. A; Exh. 35 (Tr. at 46), Exh. 5-137. These estimates were denied by DOL, but not refuted by comparable experts. In 2002, commercial insurance rates increased by more than 200% in most coal mining states in direct response to DOL's rules.

widely accepted treating doctor rule would be horrific and intolerable. It damages employer incentives to maximize health and safety at the workplace and operates irrationally to undermine the central premises of workers' compensation programs. The rule is not a common sense rule, it is nonsense.

CONCLUSION

The decision below should be reversed for the reason that a treating doctor rule is neither authorized nor appropriate.

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THE BLACK & DECKER DISABILITY PLAN,
Petitioner,

v.

KENNETH L. NORD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR THE CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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BRIEF FOR THE CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

INTEREST OF CENTRAL STATES

Central States is an "employee welfare benefit plan," and "employee benefit plan," and a "multiemployer plan" within the meaning of Sections 3(1), 3(3), and 3(37)(A) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1002(1), 1002(3), and 1002(37)(A).[1] It is administered by a ten person board of

[1] Pursuant to Rule 37.6, Central States represents that this brief has been authored solely by counsel for Central States and that no party other than Central States has made a monetary contribution for the preparation or submission of this brief.

trustees comprised of five employer trustees and five union trustees as required by Section 302(c)(5) of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 186(c)(5). Central States provides health benefits to approximately 100,000 active participants and 25,000 retirees. Pursuant to its trust agreement and plan, Central States provides various disability benefits to participants in the event a participant is disabled. Central States' trust agreement and plan give the board of trustees full discretionary authority to make benefit decisions including decisions concerning disability benefits. As a result of this discretionary authority, courts apply the arbitrary and capricious standard of review to benefit decisions made by Central States. *See, e.g., Exbom v. Central States, S.E. & S.W. Areas Health & Welfare Fund*, 900 F.2d 1138, 1141-42 (7th Cir. 1990).

As a multiemployer plan, the terms of the trust agreement and plan were initially created as the result of negotiations between various management associations and the International Brotherhood of Teamsters. The trust agreement and plan may be amended from time to time by the board of trustees that, as previously noted, has an equal number of representatives from employers and the union. As a result, the terms of the trust agreement and plan are the result of a balancing between the interests of employers and the union. Part of this balance is that the board of trustees is given discretionary and final authority to make decisions on benefit claims.

The decision below threatens to shift discretion away from plans to the participant via deference to the participant's treating physician. Recognition of a treating physician rule, while unwarranted in respect to benefit decisions of *any* ERISA plan is particularly inappropriate when a multiemployer plan is involved. The terms of the trust agreement and plan are part of a carefully negotiated balance.

In determining where the appropriate balance lies, both the employers and the union have relied on the fact that it is the decision of the board of trustees, not the participant's treating physician, which will be given deference. Because the employers and the union have premised their agreement on the appropriate terms of the plan on the board of trustees' discretion, allowing the views of the participant's treating physician to hold sway would result in the plan paying more benefit claims than anticipated at the time the plan computes the amount of contributions necessary by participating employers to fund the benefits. As a result, because a multiemployer plan depends on contributions from employers to survive, the plan will either need to cut benefits or increase contributions to make up for the increase in granted benefit claims. Either way, settled expectations are upset by the application of a rule that, as will be shown below, is entirely inappropriate in the ERISA context.

SUMMARY OF ARGUMENT

The Ninth Circuit's holding that the treating physician rule applies in the ERISA context is incorrect. Unlike the Social Security Act and its accompanying regulations, ERISA and its accompanying regulations do not incorporate the treating physician rule. Indeed, an examination of ERISA and its regulations reveals that it would be contrary to ERISA and its regulations to recognize such a rule. The treating physician rule relies upon assumptions of bias by either the plan administrator or the consulting physicians hired by the plan (as well as an assumption of the lack of bias of a treating physician) that are unwarranted and directly contrary to the discretion afforded to plan administrators. Use of the treating physician rule is particularly inappropriate when a multiemployer plan is involved because the terms of such a plan, and the discretion afforded to the plan administrator, are the result of carefully negotiated compromises between the employers that participate in the plan and the union.

Furthermore, the equal representation of employers and union on the board of trustees of a multiemployer plan make any inference of bias unwarranted. For these reasons, this Court should hold that the Ninth Circuit erred in applying the treating physician rule in the ERISA context.

ARGUMENT

The Social Security Act ("SSA") contains a provision that states that the Commissioner of Social Security shall "make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make . . . a determination [regarding disability], prior to evaluating medical evidence obtained from any other source on a consultative basis." 42 U.S.C. § 423(d)(5)(B). A regulation promulgated under the SSA provides that the "treating physician's opinion is entitled to controlling weight if it is well supported by medical findings and not inconsistent with other substantial evidence in the record." *Dixon v. Massanari*, 270 F.3d 1171, 1177 (7th Cir. 2001); 20 C.F.R. § 404.1527(d)(2). Thus, both the text of the SSA and the regulations provide a basis for the use of the treating physician rule in the social security context.

In contrast, ERISA has no statutory or regulatory basis for the use of the treating physician rule. Instead, an examination of ERISA and its regulations leads to the conclusion that application of the treating physician rule in the ERISA context is unwarranted. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court held that ERISA benefit determinations are to be reviewed by a court *de novo* "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. The rationale of this Court's holding in *Firestone* was that the interpretation of ERISA was to be guided by principles of trust law, and trust law principles indicate that deferential review is appropriate

when a trustee exercises discretionary powers. Based on this holding and rationale, the lower courts have held that the arbitrary and capricious standard of review applies to plans such as Central States that grant such discretion. *See, e.g., Exbom v. Central States, S.E. & S.W. Areas Health & Welfare Fund*, 900 F.2d 1138, 1141-43 (7th Cir. 1990). Thus, under ERISA, it is the decision of the plan administrator, not the treating physician, which is entitled to deference. As the Fifth Circuit has held in refusing to apply the treating physician rule, application of the treating physician rule requires giving deference to the treating physician's opinion which "would vitiate the discretionary authority expressly granted to [the trustees] in the contract." *Dowden v. Blue Cross & Blue Shield of Tex., Inc.*, 126 F.3d 641, 644 (5th Cir. 1997). To import the treating physician rule from the SSA to the ERISA context is inconsistent with the trust law principles that guide the interpretation of ERISA.

The use of the treating physician rule is based in large part upon the belief that disability benefits are salary replacement and therefore the treating physician in the disability context will tend to not be biased whereas the use of consulting physicians by plans is subject to bias. *See, e.g., Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1143 (9th Cir. 2001). However, the belief that a treating physician in the disability context will be unbiased is an unwarranted assumption. Many courts have noted in the health benefit context that such an assumption is unwarranted because the treating physician has an economic interest in the outcome. *See, e.g., Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992); *Jett v. Blue Cross & Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989). There may be many cases in which a participant will use disability benefits to pay for the future medical and rehabilitative services the participant needs, including

payments to the same treating physician who is supposedly unbiased. Further, as the Seventh Circuit has stated:

> We must keep in mind the biases that a treating physician may bring to the disability evaluation. "The patient's regular physician may want to do a favor for a friend and client, and so the treating physician may too quickly find disability." Additionally, we have noted that the claimant's regular physician may not appreciate how her patient's case compares to other similar cases, and therefore that a consulting physician's opinion might have the advantages of both impartiality and expertise.

Dixon, 270 F.3d at 1177 (internal citation omitted).

Second, the presumption that either the consulting physician or the plan administrator will be biased is incorrect both as a factual matter and because the presumption conflicts with ERISA. As this Court has recognized, ERISA specifically contemplates that fiduciaries of a plan may also be corporate officers. *Pegram v. Herdich*, 530 U.S. 211, 225 (2000). Additionally, the impact on the plan of granting or denying a particular claim will not be sufficiently significant as to threaten the plan administrator's impartiality. *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995). As a result, a court should not presume that bias exists and a mere showing of a potential conflict of interest is not enough to overcome the presumption of impartiality. *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998).

Further, the ERISA claim regulations specifically contemplate that plans will use consulting physicians. For example, the regulations provide that:

> [I]n deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary

> or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

29 C.F.R. § 2560.503-1(h)(3)(iii). In addition, the regulations provide that "the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual." 29 C.F.R. § 2560.503-1(h)(3)(v). The regulations quoted above also apply to disability benefit determinations. 29 C.F.R. § 2560.503-1(h)(4). These detailed regulations specifically contemplate the use of consulting physicians and provide safeguards for their impartiality. As a result, it would be unwarranted to presume that a consulting physician would be biased. Similarly, it would be unwarranted to presume that deference is to be given to the treating physician when no such deference is indicated in either the statute or the regulations. In rejecting the application of the treating physician rule to the veterans' benefit context, the Federal Circuit stated the following that is equally applicable to the ERISA context:

> Thus, unlike the Social Security benefit statutes, the VA benefits statutes and regulations do not provide any basis for the "treating physician" rule and, in fact, appear to conflict with such a rule. Moreover, given the comprehensive statutory and regulatory scheme for the award of veterans' benefits, it would not be appropriate for this court to impose the "treating physician" rule on the VA.

White v. Principi, 243 F.3d 1378, 1381 (Fed. Cir. 2001). ERISA and its regulations provide detailed rules for benefit plans to follow regarding the handling of claims. Nowhere in the statute or the regulations is the treating physician rule

mentioned and the assumptions underlying the rule are in fact contradicted by ERISA and its regulations.

Furthermore, there is even more reason to reject the use of the treating physician rule in the multiemployer plan context. The terms of a multiemployer plan reflect a delicate balance between the interests of the employers that participate in the plan and the union. *See Cozzie v. Metropolitan Life Ins. Co.*, 140 F.3d 1104, 1108 (7th Cir. 1998) (noting this fact with respect to a single employer plan created as the result of negotiations between a single employer and a union). When agreeing to the terms of the plan, the parties have expectations concerning how the plan will operate, including the discretion afforded to the plan sponsor. The carefully constructed benefits provided under the plan are agreed to by both the employers and the union with the understanding that the plan administrator will exercise the discretion conferred by the plan in a neutral fashion. Because the board of trustees (the plan administrator) consists of both employer and union representatives, "there is no conflict of interest to justify less deferential review." *Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480, 481 (9th Cir. 1990).

In the case below, the Ninth Circuit stated that because the treating physicians in this case disagreed with the consulting physician, "the plan administrator can reject the conclusions of the treating physicians only if the administrator gives specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002). Stated as a general matter, the requirement that the plan administrator have specific reasons for the benefit determination that are supported by substantial evidence is a well-settled issue. However, the Ninth Circuit has gone beyond this principal in stating that the treating physician rule "require[s] plan administrators to give *special weight* to the opinions of the treating physicians." *Regula*, 266 F.3d at 1144. Further, the

Ninth Circuit also couches the analysis in terms of a conflict of interest stating that a conflict of interest exists when there is an "insufficiency of those reasons" given by the plan administrator for denying a claim. *Nord*, 296 F.3d at 829.

An example highlights the flaw in the Ninth Circuit's use of the treating physician rule to eliminate the deference given to a plan administrator's exercise of discretion. Assume that the treating physician finds a participant to be disabled but the consulting physician does not. Assume further that although there is some evidence to support the plan administrator's decision, a court would find under *de novo* review that the evidence weighs more in favor of the participant than the plan administrator. Finally, assume that the plan grants discretion to the plan administrator to make the determination. Normally, the court would affirm the plan administrator's decision, even though the court might disagree with the plan administrator's decision, because the decision has a reasonable basis in the evidence. However, under the reasoning of the Ninth Circuit, the plan administrator would have to overcome the "special weight" given to the treating physician's opinion. Further, because the court would be of the opinion that the reasons proffered by the plan administrator were insufficient, the court would find that a conflict of interest exists and would therefore use the *de novo* standard of review. Under that standard, the court would rule against the plan administrator. Thus, deferential review would no longer exist because the court would find that the plan administrator's reasons were "insufficient" because the plan administrator has not overcome the presumption in favor of the treating physician's opinion.

Although it is not clear what quantum of evidence is insufficient, perhaps the Ninth Circuit means those cases where evidence that supports the plan administrator's decision is wholly absent or is so "insufficient" as to be no more than a "scintilla of evidence." *Nord*, 296 F.3d at 832.

However, if the evidence is so deficient that it would not meet this standard, such a determination would be held to be arbitrary and capricious even under a deferential standard of review. Therefore, unless the Ninth Circuit is imposing a higher burden on the plan administrator than merely providing some evidence in support of the plan administrator's decision, couching the treating physician rule in conflict of interest terms makes no sense.

The Ninth Circuit's use of the treating physician rule in both this case and in the *Regula* case indicates that the Ninth Circuit is using the rule to alter the traditional deference given to a discretionary decision made by the plan administrator rather than as simply another method of analyzing conflicts of interest. In the case below, the Ninth Circuit noted that the plan used a consulting physician that disagreed with the determination made by the treating physicians. Although the Ninth Circuit referred to this evidence as a "scintilla of evidence," *Nord*, 296 F.3d at 832, it seems reasonably clear that the Ninth Circuit was not merely requiring that the plan have some reasonable evidentiary basis for its decision, but instead was requiring the plan to overcome a presumption in favor of the treating physician. This is so because under deferential review, the fact that contrary evidence exists does not make a decision arbitrary and capricious. *E.g., Oldenburger v. Central States, S.E. & S.W. Areas Pension Fund*, 934 F.2d 171, 173-74 (8th Cir. 1991). In sum, although a plan administrator must consider all evidence regarding a claim, including the opinion of a treating physician, the treating physician's opinion is not entitled to "special weight" and the plan administrator's decision must be upheld under deferential review as long as there is a reasonable basis in the evidence for the decision. Similarly, the treating physician rule cannot be used as a basis for finding a conflict of interest warranting *de novo* review.

CONCLUSION

For the reasons stated, the Court should hold that the Ninth Circuit erred in its determination that the treating physician rule applies with respect to ERISA benefit decisions.

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BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF MANUFACTURERS AND THE MICHIGAN MANUFACTURERS ASSOCIATION ON THE MERITS IN SUPPORT OF THE BLACK & DECKER DISABILITY BENEFITS PLAN

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INTEREST OF THE *AMICI CURIAE*[1]

The National Association of Manufacturers ("NAM") is the nation's largest industrial trade organization. NAM represents 14,000 members, including 10,000 small and mid-sized companies, and 350 member associations serving manufacturers and employees in every industrial sector and all 50 states.

The Michigan Manufacturers Association ("MMA") is a business association composed of 3,000 private Michigan businesses. An important aspect of MMA's activities is representing the interests of its member-companies in matters of paramount importance before the courts, the United States Congress, the Michigan Legislature, and governmental agencies. MMA appears before this Court as a representative of private business concerns employing over 90% of the industrial work force in Michigan – over one million employees – many of whom are affected by the issues in the case presently before the Court.

Members of the NAM and MMA provide disability benefits to their employees under disability plans similar to the plan at issue before the Court. Like the employer in the case before the Court, these members are frequently both the sponsor and the administrator of their employee benefit plans. As plan administrators, they are keenly aware of

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[1] Pursuant to Rule 37.6, (1) counsel for a party to this case has not authored this brief in whole or in part, and (2) no person or entity other than the *amici curiae* listed above has made a monetary contribution to the preparation of submission of this brief. Pursuant to Rule 37.3(a), *amici curiae* have received written consent of all parties to file this brief.

their fiduciary responsibilities under ERISA and its regulations. The NAM and MMA submit this brief *amici curiae* in support of The Black & Decker Disability Benefits Plan to focus the Court's attention on the irreconcilable conflict between ERISA's explicit statutory provisions for administrators/fiduciaries and the court of appeals' decision in this case.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Black & Decker Disability Benefits Plan ("Plan") provides benefits when the administrator determines, in its "sole and absolute discretion," that there is satisfactory medical evidence that the employee suffers from "the complete inability . . . to engage in his regular occupation with the Employer[.]"[2] Kenneth Nord applied for Plan benefits, contending that he was unable to perform his sedentary job. An independent neurologist examined Nord and concluded that he was able to perform sedentary work "with some walking interruptions."[3] After reviewing the independent neurologist's report and information submitted by Nord, including the conclusions of his treating physicians,[4] the Plan's third-party claims administrator

[2] *Nord v. The Black & Decker Disability Benefits Plan*, 296 F.3d 823, 826, n.1 and n.2 (9th Cir. 2002). This definition of disability applies to the first 30 months of Plan benefits, the benefits at issue in the case. *Id.*

[3] *Id.* at 830.

[4] In addition to medical evidence, Nord submitted answers to hypothetical questions that his attorney had posed to a human resources representative who worked at the same company that employed Nord. The Plan administrator discussed the responses with the human

(Continued on following page)

denied Nord's claim.[5] Nord appealed, and after a second review, the Plan administrator itself – the Black & Decker Corporation – concluded that Nord was ineligible for Plan benefits.[6] Nord then asked the United States District Court to award benefits. After reviewing the administrator's decision for abuse of discretion, the District Court upheld the denial, holding that it did not conflict with the Plan's terms and was not based on clearly erroneous factual findings.

Nord appealed to the United States Court of Appeals for the Ninth Circuit, which reviewed the administrator's decision *de novo*, reversed, and ordered payment of benefits. The court of appeals determined that *de novo* review was appropriate because the Plan administrator acted with an "inherent" conflict of interest and breached a fiduciary obligation to Nord. The court of appeals applied the so-called "treating physician rule" found in Social Security regulations and determined that Nord was entitled to Plan benefits, since the Plan administrator failed to demonstrate "substantial evidence" to overcome the treating physicians' conclusions that Nord was disabled. The Plan challenged the court of appeals' decision in a petition for certiorari, granted by this Court on January 10, 2003.

The National Association of Manufacturers and the Michigan Manufacturers Association, as *amici curiae*,

resources representative during review of Nord's claim. *The Black & Decker Disability Benefits Plan's Petition for Writ of Certiorari*, pp. 5-7.

[5] *Id.* at 827.

[6] *Id.*

support the Plan's position that the court of appeals erred. The court of appeals' decision rests on three errors:

First, the court of appeals wrongly assumed that there is an "inherent conflict of interest" between an employer serving as administrator of a benefit plan and an individual seeking plan benefits. This assumption, which directly conflicts with ERISA's provision that the funding sponsor is a proper plan administrator, led the court to second-guess the administrator's decision.

Second, the court of appeals wrongly assumed that the administrator breached a fiduciary duty to Nord by not applying the so-called "treating physician rule," thereby triggering *de novo* review of the administrator's decision. The alleged "breach" is not a violation of ERISA or its regulations. Instead, the administrator acted as a proper ERISA fiduciary should – for the benefit of the Plan as a whole, following Plan terms.

Third, the court of appeals erroneously applied the "treating physician rule" to ERISA-governed benefits. This rule interferes with the freedom of contract preserved under ERISA, is inconsistent with regulations promulgated by the Department of Labor, and will most likely escalate the cost of providing disability benefits.

If these errors are not corrected, plan sponsors will no longer be free to design objective procedures for determining disability. They will be unfairly penalized for serving as administrators, and their administrative decisions will be continually challenged in court. Under the conditions employers will be reluctant to provide disability benefits at all.

Amici curiae urge this Court to reverse the court of appeals on all three points, as set forth in detail below.

ARGUMENT

I. UNDER ERISA, THERE IS NO "INHERENT CONFLICT OF INTEREST" BETWEEN AN EMPLOYER SERVING AS PLAN ADMINISTRATOR AND AN INDIVIDUAL SEEKING BENEFITS.

The Ninth Circuit has only applied the so-called "treating physician rule" in cases where it was concerned that the administrator was acting under an "inherent conflict of interest" as the plan's sponsoring employer. *Regula v. Delta Family-Care Disability and Survivorship Plan*, 266 F.3d 1130, 1142-1144 (9th Cir. 2001);[7] *Nord v. The Black & Decker Disability Benefits Plan*, 296 F.3d 823, 828 (9th Cir. 2002). It is evident that the court has imposed the "treating physician rule" in an attempt to counteract this perceived "inherent conflict." Although the court can legitimately consider whether the administrator acted with a "conflict of interest,"[8] ERISA makes clear that

[7] In *Regula*, the court of appeals raised the "conflict of interest" issue *sua sponte*, finding "the apparent existence of a conflict" and remanding "for a proper determination as to the administrator's impairment due to a conflict of interest." *Regula*, 266 F.3d at 1144.

[8] This Court has commented that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (quoting Restatement (Second) of Trusts § 187, Comment *d* (1959)).

the "conflict" that triggered the court of appeals' concern in *Regula* and *Nord* simply does not exist.

The court of appeals correctly noted that the Plan administrator is a "fiduciary" under ERISA's definition of that term.[9] The court of appeals then assumed, without any statutory analysis, that the common law of trusts defines the scope of the ERISA fiduciary's "conflict of interest." Relying on the common law of trusts,[10] the court of appeals held that, as the employer who funded the plan, the administrator had "an inherent conflict of interest" that could amount to a breach of fiduciary duty to Nord.[11]

[9] The concept of a fiduciary dates back to Roman times, and there is a considerable amount of common-law jurisprudence related to fiduciaries. *Cf.* definition of "fiduciary" in *Black's Law Dictionary* 625 (6th Ed. 1990). ERISA, however, supplies its own definition of the term "fiduciary" that is somewhat different than common law. 29 U.S.C. § 1002(21)(A). The statute also contains lengthy provisions establishing the proper role and responsibilities of an ERISA fiduciary. *See* 29 U.S.C. § 1104 (imposing a prudent person standard and requiring the fiduciary to act with respect to a plan solely in the interests of participants and beneficiaries); § 1106 (prohibiting types of self-dealing between the plan and defined "parties in interest"); § 1108(c)(2) (prohibiting additional compensation for fiduciaries who are full-time employees of unions or employers).

[10] *Nord* referred vaguely to the common law of trusts without identifying the particular source of this "common law." *Nord* relied on the Ninth Circuit case, *Lang v. Long-Term Disability Plan*, 125 F.3d 794 (9th Cir. 1997). *Lang*, in turn, relied upon *Brown v. Blue Cross & Blue Shield of Alabama, Inc.* 898 F.2d 1556, 1561-67 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) (concluding that certain ERISA plans are not "true trusts" under common law and are, therefore, entitled to "less" deference).

[11] *Nord*, 296 F.3d at 828-829. In fact, the employer's administrative duties had been delegated to a third-party administrator, Metropolitan Life Insurance Company. The court of appeals held, without any legal or factual support, that the third-party administrator acted as the

(Continued on following page)

Finding this "inherent conflict of interest" was the first of two errors that led the court of appeals to review the administrator's decision *de novo*.[12]

But the common law of trusts is not controlling. Although ERISA requires plan administrators to follow fiduciary standards that are similar to the common law of trusts, Congress expected courts to interpret ERISA's standards "bearing in mind the special nature and purpose of employee benefit plans." *Varity v. Howe,* 516 U.S. 489,

agent of the employer and so also "was operating under an inherent conflict of interest." *Id.*

[12] When a benefit plan gives its administrator discretion to determine eligibility, as the Plan did in this case, *Nord*, 296 F.3d at 826, the administrator's decision is entitled to deference, and the court reviews the decision for an abuse of discretion. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The deferential standard ensures that the administrator's decision will be upheld if it was rational and consistent with the terms of the benefit plan. *Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689, 693 (6th Cir. 1989), *cert. denied*, 495 U.S. 905 (1990). But where there is evidence that the administrator acted under an actual conflict of interest, the courts have weighed the conflict as one factor to be considered upon review, usually still according some deference to the administrator. The different circuits have different approaches to determining the standard of review when the plan administrator has a conflict of interest. Compare *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1255-56 (2nd Cir. 1996) (applying a test following Section 187 of the Restatement (Second) of Trusts) with *Brown v. Blue Cross and Blue Shield of Alabama, Inc.* 898 F.2d 1157, 1566-67 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) (utilizing a burden-shifting approach that favors the plan participant). In this case, it is unnecessary to determine the precise test to apply, since the court of appeals found a "conflict" where none was actually present.

497 (1996) (quoting H.R. Conf. Rep. No. 93-1280, pp. 295, 302 (1974), 3 Leg. Hist. 4562, 4569). Thus, "the law of trusts often will inform, but will not necessarily determine the outcome of, an effort to interpret ERISA's fiduciary duties." *Varity*, 516 U.S. at 498. While trust law offers a "starting point, . . . courts must go on to ask whether, or to what extent, the language of [ERISA], its structure, or its purposes require departing from common-law trust requirements." *Id.* If it is incongruent with ERISA, then the common law of trusts simply does not apply.[13]

Examining the statute itself shows that Congress saw no inherent conflict of interest in allowing the plan sponsor – usually the employer – to administer plan benefits. Congress specifically provided that the plan sponsor would be the plan administrator, unless the plan expressly appoints a different entity. *See* 29 U.S.C. § 1002(16)(A).[14] In so doing, Congress knew full well that the plan sponsor

[13] *See Mertins v. Hewitt Associates*, 508 U.S. 248, 261-263 (1993) (pointing out that ERISA's definition of fiduciary differs from that of common law and strictly applying the statute despite the argument that strict construction eliminated remedies available under common law).

[14] Indeed, the term "sponsor," by definition, refers to the entity establishing and maintaining (i.e., funding) the plan. 29 U.S.C. § 1002(16)(A) provides:

> The term "administrator" means –
>
> (i) the person specifically so designated by the terms of the instrument under which the plan is operated;
>
> (ii) if an administrator is not so designated, the plan sponsor; or
>
> (iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

funds the benefits (*see* 29 U.S.C. § 1002(16)(B)),[15] but did not view funding as an inherent conflict of interest. Indeed, ERISA expressly permits the employer to serve as plan administrator, although this arrangement might be prohibited under the common law of trusts. *Varity*, 516 U.S. at 498.

The National Association of Manufacturers and the Michigan Manufacturers Association urge this Court to correct the court of appeals' erroneous determination that there is an "inherent" conflict of interest present whenever the funding employer serves as plan administrator.

II. THE COURT OF APPEALS ERRED BY FINDING A "BREACH" OF A "FIDUCIARY DUTY" THAT DOES NOT EXIST UNDER ERISA.

Generally, the courts agree that if the administrator/fiduciary acts under a conflict of interest, the conflict is one factor considered upon review of the administrator/fiduciary's decision.[16] In contrast, the Ninth Circuit

[15] 29 U.S.C. § 1002(16)(B) provides, in relevant part:

> The term "plan sponsor" means:
>
> (i) the employer in the case of an employee benefit plan established or maintained by a single employer,
>
> (ii) the employee organization in the case of a plan established or maintained by an employee organization, or
>
> (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

[16] *See* n.12.

completely rescinds the administrator's discretion and conducts *de novo* review of the administrator's decision if it finds that the administrator breached a fiduciary duty "to the participant." *See Lang*, 125 F.3d 794, 798 (applying *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323-24 (9th Cir. 1995)). Here, the court of appeals determined that there was actual evidence "that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary."[17] The "evidence" of the "breach" was not a violation of ERISA, its regulations, or the terms of the plan. Instead, it consisted of the administrator's "failure" to apply the so-called "treating physician rule" – a "rule" that is not found in ERISA, its regulations, or the plan's terms, and did not apply to ERISA plans when the administrator decided Nord's claim.[18] For a second time, the court of appeals improperly analyzed the issue by failing to consider the statute and its regulations.

The court of appeals began with the incorrect assumption that the administrator's "fiduciary obligation to the beneficiary" is called into question when the administrator denies benefits.[19] This focus on the *individual* beneficiary's interest is improper. Under ERISA, the administrator has fiduciary responsibility for the *plan as a whole* and for

[17] *Nord*, 296 F.3d at 829.

[18] The "treating physician rule" was first applied to ERISA plans in *Regula v. Delta Family-Care Disability and Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), long after the Plan administrator denied Nord's appeal on October 27, 1998. *See Nord*, 296 F.3d at 827.

[19] The court of appeals stated that it must determine whether "the affected beneficiary" provided evidence showing "that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations *to the beneficiary*." *Nord*, 296 F.3d 823, 829 (emphasis added).

participants and beneficiaries *as a group*. 29 U.S.C. § 1104(a)(1)(A).[20] This Court analyzed the detailed statutory provisions for ERISA fiduciaries, and the legislative history, and concluded that under ERISA, the fiduciary relationship exists between the fiduciary and the plan, not the individual participant. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 (1985) (rejecting proposition that individual participant may recover damages based upon administrator's breach of fiduciary duty in processing claim for benefits). This distinction is important, because the individual's interests may be at odds with the interests of the plan as a whole. For example, awarding benefits to an ineligible individual serves the individual's interests, but harms the plan's interests, since the plan is designed to limit benefits to eligible individuals and must conserve resources for those who truly qualify under the plan. *See* E. Haavi Morreim, *Benefits Decisions in ERISA Plans: Diminishing Deference to Fiduciaries and an Emerging Problem for Provider-Sponsored Organizations*, 65 Tenn. L. Rev. 511, 523-526 (1998) (pointing out that courts often confuse conflicts of interest that affect the benefit plan with conflicts of interest that affect an individual participant).

[20] 29 U.S.C. § 1104(a) provides, in relevant part:

> (1) . . . a fiduciary shall discharge his duties with respect to the plan solely in the interests of the participants and beneficiaries and –
>
> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the plan [.]

Since the fiduciary's responsibility is to the plan, and since ERISA requires fiduciaries to follow "the documents and instruments governing the plan,"[21] the administrator's actions must be evaluated in light of the plan's terms. Plan terms are critical because eligibility for disability benefits depends entirely upon the provisions of the particular plan; ERISA does not govern a disability plan's substantive content. *Massachusetts Mut. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985). Yet the court of appeals virtually ignored the Plan in *Nord*, relegating its controlling provisions to footnotes in the "Factual and Procedural Background" portion of the opinion, without further discussion.[22] This disregard of Plan terms is consistent with the Ninth Circuit's astonishing and unprecedented assertion in *Regula* that "we reject the view that disability determinations under ERISA are determined almost exclusively by plan language[.]" *Regula*, 266 F.3d 1130 at 1140.

Ignoring the Plan's terms and the administrator's statutory duty to follow the terms, the court of appeals accuses the administrator of violating its fiduciary

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[21] 29 U.S.C. § 1104 provides, in relevant part:

(a) Prudent man standard of care.

(1) Subject to sections 403(c) and (d), 4042, and 4044, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV.

[22] *See Nord*, 296 F.3d at 826, n.1 and n.2.

responsibility (to Nord) by "reject[ing] . . . the conclusion of its own human resources representative . . . [who] opined that Nord was unable, due to his medical condition, to perform the functions" of his job."[23] The court of appeals attacked the administrator as "high-handed" for "contradict[ing]" the human resource representative's opinion. This criticism is entirely unwarranted: under the Plan's terms, the administrator must determine disability by reviewing "suitable *medical* evidence" and "the Participant's prior employment history."[24] The human resources representative's responses to hypothetical questions posed by Nord's attorney are not "medical evidence" or "prior employment history" and, therefore, were properly excluded under the Plan's own terms.

The court of appeals also accused the administrator of violating fiduciary responsibility (to Nord) by rejecting "the prevailing opinions of Nord's treating physicians," holding that "under the treating physician rule, the plan administrator can reject the conclusions of the treating physicians only if the administrator 'gives specific, legitimate reasons for doing so that are based upon substantial evidence in the record.'"[25] The "treating physician rule" is not a Plan term and is not a part of the Plan's procedure for determining benefit eligibility. The Plan never suggests that the treating physician's opinion is entitled to deference; instead, the Plan instructs the administrator to consider "suitable medical evidence and a review of the

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[23] *Nord*, 296 F.3d at 830.

[24] *Nord*, 296 F.3d at 826, n.1.

[25] *Nord*, 296 F.3d at 830-831 (quoting Social Security case, *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999)).

Participant's employment history" and gives the administrator "sole and absolute discretion" to determine which medical evidence is satisfactory.[26] Accordingly, the administrator simply cannot apply the "treating physician rule" without shirking its ERISA fiduciary responsibilities to follow Plan documents and protect the integrity of the Plan.

III. UNDER ERISA, THE ADMINISTRATOR'S DECISION MUST CONFORM TO THE PLAN'S TERMS, THE STATUTE, AND THE APPLICABLE REGULATIONS - NOT THE OPINION OF THE TREATING PHYSICIAN.

The court of appeals held that *Nord* was controlled by its decision in *Regula*. In *Regula*, the court found that the "treating physician rule" used in Social Security Disability cases should apply to ERISA disability claims "for reasons having to do with common sense as well as consistency in our review of disability determinations where benefits are protected by federal law[.]" *Regula*, 266 F.3d 1130 at 1139. Without relying on ERISA, its regulations, or even the common law of trusts, *Regula* concludes that "[a] guiding principle such as the treating physician rule that is effective in helping plan administrators make fair and accurate disability determinations is consistent with [ERISA's] goal" of "protect[ing] the rights of participants and beneficiaries." *Regula*, 266 F.3d at 1143.

The court of appeals grossly over-simplified ERISA's purpose. ERISA is "an enormously complex and detailed statute that resolved innumerable disputes between

[26] *Nord*, 296 F.3d at 826, n.1.

powerful competing interests – not all in favor of potential plaintiffs." *Mertins v. Hewitt Associates*, 508 U.S. 248, 262 (1993). More importantly, "vague notions of a statute's 'basic purpose'" cannot overcome ERISA's explicit provisions, which resulted from a decade of congressional study of employer-sponsored benefits. *Id.* at 261 (quoting *Pension Benefit Guaranty Corp. v. LTV Corp.*, 496 U.S. 633, 646-647 (1990)) and 251. "The authority of courts to develop a 'federal common law' under ERISA . . . is not the authority to revise the text of the statute." *Id.* at 257 (internal citation omitted).

As this Court has often noted, ERISA preserves the autonomy of employers and employees to negotiate whether health or disability benefits will be provided at all and allows them to set the terms and conditions of those benefits. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) ("ERISA does not mandate that employers provide any particular benefits"); *Massachusetts Mut. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 at 732 (ERISA "does not regulate the substantive content of welfare-benefit plans"); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (Congress deliberately did not create any substantive entitlement to employer-sponsored health or disability benefits, leaving "employers . . . generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans").

Employers chose plan terms carefully to restrict benefits to those who are truly unable to perform work, avoiding provisions that allow malingerers to refuse to return to work. By grafting Social Security's "treating physician rule" onto ERISA, the court of appeals disrupts the freedom to contract for benefits that Congress so carefully preserved in the statute. Regardless of the terms

chosen by the plan's sponsor, the rule of *Regula* and *Nord* now imposes a presumption that disability benefits must be paid if the treating physician concludes that disability exists; allocate the burden of overcoming the treating physician's conclusion to the administrator; and set the level of proof that an administrator must satisfy in order to deny benefits. Since the treating physician will generally advocate on the patient's behalf and find disability,[27] and since the rule fails to provide clear instruction for obtaining "substantial evidence" to overcome the treater's conclusion, the administrator is faced with the unpleasant task of awarding benefits in cases where the plan never intended benefits be paid.

Although the Department of Labor is empowered by ERISA to promulgate *procedural* – not substantive – regulations for administrative claim review,[28] the

[27] The American Medical Association's ethical guidelines for the treating physician require the physician to advocate on behalf of the patient when dealing with third parties. *American Medical Association Code of Ethics, E-10.01, Patient-Physician Relationship In General,* (6) (July 15, 2002). In contrast, physicians performing an independent medical examination have an ethical duty to evaluate the patient's health or disability "objectively." *Id., E-10.03, Patient-Physician Relationship in the Context of Work and Independent Medical Examinations,* (1) (July 17, 2002).

[28] 29 U.S.C. § 1133 provides:

> Claims procedure
>
> In accordance with regulations of the Secretary, every employee benefit plan shall –
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

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regulations it has issued do not affect the sponsor's freedom of contract or the substantive provisions of a plan. *See* 29 C.F.R. §§ 2560.503-1(h). The regulations do not disturb the plan's ability to allocate the burden of proof to the individual seeking benefits and do not establish a presumption that the individual's treating physician's conclusion is entitled to deference.

In stark contrast to ERISA-governed disability benefits, Social Security disability benefits are a *public entitlement* established by Congress for workers and their eligible dependants. *See Mathews v. Eldridge,* 424 U.S. 319, 323, n.1, and 336 (1976). These benefits are funded by taxes and administered by state and federal agencies following detailed standards and procedures developed by the Secretary of Health and Human Services. *Id.* at 335-336. A determination of disability by the Social Security Administration ("SSA") does not take into account detailed, workplace-specific matters such as whether the individual could perform his or her job with a reasonable accommodation. *Cleveland v. Policy Management Sys. Corp.*, 526 U.S. 795, 803 (1999). Because the SSA must process more than 2.5 million disability claims each year on limited administrative resources, it relies on a set of regulatory presumptions that "inevitably simplify, eliminating consideration of many differences potentially relevant to an individual's ability to perform a particular job." *Id.* at 804. Thus, Social Security disability benefits

> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

may be granted to an individual who still "remain[s] capable of 'performing the essential functions' of her job." *Id.*

The presumptions followed by the SSA, including the treating physician rule, have no place in The Black & Decker Disability Benefits Plan. The Plan was designed to provide benefits only to an employee with "the complete inability . . . to engage in his regular occupation with the Employer." If an employee can perform the job with reasonable accommodation, such as the "walking interruption" that the neurologist found would allow Nord to perform his job, then by its terms, the Plan does not provide benefits.[29]

If the treating physician rule is upheld in this case, the court of appeals' misguided attempt to help disability claimants will ultimately cause a significant reduction in the number of employers who choose to offer employees this benefit. The administrative uncertainty created by the rule will discourage employers from offering disability benefits. *See Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (recognizing that in creating ERISA, Congress attempted to balance desire to offer employees enhanced benefit protection against the burden of a system whose administrative costs or litigation expenses would unduly discourage employers from offering the benefit in the first place).

[29] *Nord*, 296 F.3d at 826, n.1 and 830.

CONCLUSION

This Court should overturn the decision of the Court of Appeals for the Ninth Circuit and remand this case for entry of a decision consistent with this Court's opinion.

Respectfully submitted,

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In The
Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

BRIEF OF AMERICAN COUNCIL OF LIFE INSURERS, UNUMPROVIDENT CORPORATION, AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Amici will address the following question:

1. Whether the Ninth Circuit erred in holding that an ERISA disability claims administrator's determination of disability is subject to the "treating physician rule" and, therefore, the claims administrator is required to accept a treating physician's opinion of disability as controlling unless the claims administrator rebuts that opinion in writing based on substantial evidence in the record?

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INTEREST OF THE *AMICI CURIAE*[1]

The American Council of Life Insurers ("ACLI")

ACLI, a non-profit trade association, is the largest trade association in the United States representing the life insurance industry. The ACLI's members include the 383 legal reserve life insurers, accounting for 70 percent of life insurance premiums in the United States. ACLI advocates the interests of its members before federal and state legislators, state insurance departments, federal regulatory agencies, and the courts. ACLI files this Brief to communicate and support the concerns and interests of its members that handle disability claims for employers. In particular, it shares the concerns of UNUMProvident Corp. as set forth in detail below.

The Health Insurance Association of America ("HIAA")

HIAA is the nation's most prominent trade association representing the private health care system. Its nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. HIAA develops and advocates federal and state policies that build upon the health care system's quality, affordability, accessibility and responsiveness. HIAA's member companies that are engaged in the disability

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[1] Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this Brief *amici curiae*. Their letters of consent have been filed with the Clerk of the Court.

Pursuant to Rule 37.6 of the Rules of this Court, *Amici* state that this brief was not authored in whole or in part by counsel for a party, and no person or entity, other than *Amici*, made a monetary contribution for the preparation or submission of this brief.

income insurance marketplace, share the concerns detailed below by UNUMProvident Corp.

UNUMProvident Corp.

UNUMProvident Corp. is the parent holding company of UNUM Life Insurance Company of America, The Paul Revere Life Insurance Company, and Provident Life and Accident Insurance Company (collectively, the "UNUMProvident Companies"). The UNUMProvident Companies are three of the largest disability insurance carriers in the United States. They are authorized to issue individual and group disability policies in all 50 States. Many of these policies fund disability benefits under employee welfare benefit plans regulated by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* ("ERISA").

The UNUMProvident Companies collectively receive approximately 400,000 new disability claims each year. Last year alone, the UNUMProvident Companies paid approximately 3.6 billion dollars in disability benefits and provided assistance to approximately 500,000 individuals and families. The UNUMProvident Companies sell their policies and services to employers who wish to allocate their scarce resources to providing an efficient and consistent plan for making available disability benefits and return to work services for their employees.

In order to accomplish this goal, the UNUMProvident Companies directly employ approximately 100 physicians and 350 nurse care managers and vocational rehabilitation specialists. In addition, the UNUMProvident Companies draw upon approximately 1,000 nurses and vocational rehabilitation specialists of a separate UNUMProvident subsidiary, for field-based case management and rehabilitation services. In 2002, the UNUMProvident Companies

spent $60 million for medically related services. The UNUMProvident Companies also employ "impairment based" claims processes with separate units handling discrete medical specialties such as cancer, cardiac and orthopedics. This process allows the UNUMProvident Companies to better leverage their base of knowledge and resources.

The UNUMProvident Companies go to these lengths to achieve accurate, fair and consistent determinations across the country. Brokers and consultants recommend the UNUMProvident Companies to their employers based on the UNUMProvident Companies' reputation for fairness and their specialized expertise. Without accurate, fair and consistent decision-making, the UNUMProvident Companies' customers (22% of the Fortune 500 and approximately one out of every four companies in North America) would no longer choose the UNUMProvident Companies as their disability carrier. To succeed in the marketplace, the UNUMProvident Companies thus face the challenge of minimizing the costs of their products, while ensuring that benefit determinations are made in accordance with the requirements of ERISA and achieve the goals of accuracy, fairness and consistency.

The UNUMProvident Companies have strived to meet those goals within the current ERISA framework. Of the approximately 400,000 new disability claims filed in 2001, approximately 90% were paid. Of the remaining claimants, approximately one-half were no longer claiming benefits when payments would have begun, roughly 2% were determined **not** to be disabled, and the remainder were denied benefits for reasons irrespective of whether they were disabled or not (*e.g.*, policy exclusions, etc.). At the end of the day, less than ½ of 1% of claimants resort to lawsuits. There is no reason to believe that these statistics are unique throughout the industry.

In short, whether the insurer is one of the UNUM-Provident Companies or one of ACLI's or HIAA's members, the fact is that the claims that reach the courts, including the rare and occasional claim that plaintiffs' counsel hype as evidence of unfair practices, represent a miniscule portion of the huge volume of claims made under the policies issued. Courts resolve those claims under ERISA by insuring that the challenged decisions are not arbitrary, and try to do this in a speedy and cost-effective manner that minimizes the very substantial costs of litigation that would otherwise be borne, ultimately, by employers. Year in and year out, employers have tended to find that this current regime under ERISA provides a benefit to their employees sufficient to induce more and more employers to commit the resources necessary to fund the policies. And each year more and more employees and unions find that the plans offer sufficient value so as to be seen as a form of significant compensation. The UNUMProvident Companies themselves, and on behalf of their customers, and ACLI and HIAA on behalf of their members and their customers, thus possess strong interests in ensuring that Congress's brilliant creation known as ERISA does not lose the genius of its balance between minimizing costs and maximizing benefits for employees.

The rule applied by the Ninth Circuit disrupts this balance and signals a slide down the slope of increased costs and litigation, as explained below in detail. Because these consequences would injure employers, employees and insurers throughout the Nation, the UNUMProvident companies, ACLI, and HIAA submit this Brief to assist the Court in the resolution of this case.

SUMMARY OF ARGUMENT

Under prevailing interpretations of Congressional intent, employers have the ability to set up disability benefit plans under which a claims administrator is given broad discretion to determine whether a beneficiary is eligible for benefits. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-111 (1989). This discretion, of necessity, includes the ability to weigh conflicting evidence. Until now, this regime has successfully promoted Congress' intent of creating fair and efficient claims settlement procedures and encouraging the formation of benefits plans.

The Ninth Circuit has now turned this regime on its head. On the basis of demonstrably flawed stereotypes, the Ninth Circuit has granted to so-called treating physicians a presumptive authority over the decisions of claims administrators. In fact, the Court of Appeals went a step further by holding that a claims administrator's exercise of his discretion to weigh evidence constituted a conflict of interest resulting in the forfeiture of that very discretion. This rule and its circular application deprives claims administrators of the ability to make nuanced, fact-sensitive judgements without greatly increasing administrative costs. Identical benefits claims would no longer depend on uniform medical standards, but rather on which "treating physician" is selected. And it paves the way for courts to end-run claims administrators' discretion by mandating deference to any evidence the court thinks is more credible. Adoption of the rule would increase both administrative and litigation costs, thereby unduly discouraging employers from offering welfare benefit plans.

This Court should reverse.

ARGUMENT

I. THE TREATING PHYSICIAN RUBRIC CONCEALS A FACT-SENSITIVE DIVERSITY OF RELATIONSHIPS AND CIRCUMSTANCES THAT DEFY A ONE-SIZE-FITS-ALL RULE.

The Ninth Circuit premised its decision in *Regula* (upon which the Court of Appeals relied in this case) on the notion that adoption of the "treating physician rule" will lead to more accurate decision-making. *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001). This belief is premised on the notion that the so-called "treating physician" is entitled to special deference because she "is employed to cure and has a greater opportunity to know and observe the patient as an individual." *Id.* at 1139.

The Ninth Circuit apparently presumes that the "treating physician" is a single known entity, a common factor in every case, warranting a common and heavy presumption of correctness. The Ninth Circuit seems to presume, further, that the opinions of so-called treating physicians, with a high degree of uniformity, are based on information that only they possess, are within their expertise, are based on nationally uniform standards, and are unaffected by undue deference to self-reported symptoms that are not consistent with the objective medical evidence. Such presumptions form the presumed basis for a "one-size-fits-all" rule to be applied in all ERISA cases involving disabilities.

These presumptions have been adopted without any evidence of investigation, rule-making proceedings, or even careful analysis. In practice, these presumptions are the product of stereotypical thinking that entirely overlooks the diverse, fact-sensitive situations confronted by claims administrators day in and day out. A claims administrator who reads the Ninth Circuit opinions cannot even

tell what a treating physician is, when, exactly the treating physician's opinions are due deference, or what types of "substantial evidence" need be relied upon to rule otherwise (other than that a contrary opinion by a qualified examining doctor is not enough).

As is often the case with broad-brush pronouncements based on stereotypes, the Ninth Circuit's treating physician rule fits poorly with the variety of actual circumstances presented by the real world.

A. The Nature Of The Claims Process Requires Case-By-Case Exercise Of Discretion.

The disability claim process is typically initiated by a contact from the claimant, requesting the necessary application forms. These forms frequently include a statement by the claimant (including background information regarding employment, coverage under the policy, alleged disability, and medical treatment information); a statement by the claimant's employer (including job description and earnings information); and a statement by the claimant's treating doctor (including treatment information, diagnosis, prognosis, restrictions and limitations). If medical records are not submitted with the claim forms, claims administrators typically request records from the claimant's physician(s). Claims administrators may also request further information from the employer regarding job duties.

Once the medical information is received, it is frequently referred to in-house medical departments for evaluation. Medical departments typically consider several factors such as whether the records actually support the conclusions in the initial claim forms and, ultimately, whether the records support the restrictions and limitations alleged in support of the claim. This portion of the claim review process may result in one or more of a number

of responses from the medical department. For example, the medical department may conclude that the information submitted is sufficient to demonstrate a disability or it may conclude that the information on its face demonstrates that the claimant is not disabled. On the other hand, the medical department may recommend that claims personnel obtain additional information or clarification of discrepancies in the records. The medical department may also recommend an independent medical examination or a functional capacity examination. The latter test is designed to measure the claimant's specific medical restrictions and limitations to determine the types of occupations the claimant is capable of performing.

Where vocational information is obtained or submitted, the claims administrator may also seek advice from trained vocational and rehabilitation personnel in appropriate cases. The purpose of these reviews is to determine the exact requirements of the claimant's occupation. Where disability benefits are paid based on whether the claimant can perform the material duties of any occupation, other tests/studies may be performed, such as a transferable skills analysis (to determine whether the claimant's education and job skills can be translated into other occupations) and/or a labor market survey (to determine whether there are available jobs in a given geographical market).

Once all of the information is gathered and analyzed, claims administrators determine whether the claimant is entitled to benefits under the terms of the benefit plan. Each claim stands on its own merits. This necessarily means that some claims may be determined based on a small amount of information whereas other claims require a substantial amount of information. The point is that each and every claim must be decided independently of each and every other claim with claims administrators balancing the information in each specific claim file. Once

a decision is rendered, the claimant is notified in writing in accordance with the requirements of ERISA, section 503 and accompanying DOL claim procedure regulations.

ERISA permits a claimant whose claim is denied in whole or in part at least one appeal. When a claimant provides notice of his request for an appeal, the matter is reviewed from scratch, with referrals to medical and/or vocational experts as appropriate. Additional information is sometimes submitted by the claimant or obtained by the claims administrator on appeal. After thorough review, the claims administrator issues a written notice to the claimant, explaining its decision and either overturning or affirming the initial denial.

In summary, the claim review process is a deliberate, detailed, thorough, process. The process is also flexible and is tailored to the particular circumstances of a given claim. Information from the treating physician is seriously considered and in some cases may be the only information necessary to determine whether benefits are payable. In other cases, the treating physician's opinion may only be a fraction of the information relevant to the claim. In all cases, the claims administrator must consider all of the relevant evidence before rendering a decision on a particular claim.

B. The Existing Legal Regime Under ERISA Appropriately Allows The Administrator To Exercise Discretion Based On The Particular Facts Of Each Claim.

Prior to the Ninth Circuit's ruling in *Regula*, circuit courts, including the Ninth Circuit, followed this Court's mandate in *Firestone* by holding that where plan documents expressly grant discretion, the proper exercise of that discretion includes the function to weigh conflicting evidence. *See Firestone*, 489 U.S. at 110-111. *See also e.g.*,

Vlass v. Raytheon Employees Disability Trust, 244 F.3d 27, 32 (1st Cir. 2001); *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 (8th Cir. 2001); *Threadgill v. Prudential Securities Group, Inc.*, 145 F.3d 286, 295 (5th Cir. 1998); *Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 (9th Cir. 1996); *Abnathya v. Hoffman LaRoche, Inc.*, 2 F.3d 40, 45 (3rd Cir. 1993); *Pratt v. Petroleum Prod. Mng. Inc. Employee Sav. Plan & Trust*, 920 F.2d 651, 658 (10th Cir. 1990). Obviously, this includes the ability to weigh conflicting medical evidence. *See Leahy v. Raytheon Co.*, 315 F.3d 11, 19 (1st Cir. 2002) ("Indeed, when the medical evidence is sharply conflicted, the deference due to the claims administrator's determination may be especially great."). Accordingly, decisions about how much weight to give so-called "treating physicians" were made on a case-by-case basis.

Depending on those variations, many benefits denials were upheld despite the existence of evidence supporting disability from treating physicians. *See Vlass*, 244 F.3d at 30-32 (upholding judgment for defendant even though treating physician's reports supported finding of disability); *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 186-87 (1st Cir. 1998) (reversing judgment for plaintiff notwithstanding treating physician's opinion that plaintiff was disabled). Depending on those variations, and without reliance on any hard and fast rule, some determinations rejecting treating physicians' opinions were overturned. *See Salley v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (rejecting treating physician rule but holding that fact-specific weighing of all medical evidence could not support denial of benefits).

In adopting a deferential standard, the hallmark of which is the claims administrator's ability to weigh evidence where plan documents gave him the discretion to do so, the circuits were not only following *Firestone*, but also the legislative purposes underlying ERISA and sound

public policy. While this Court in *Firestone* rejected a deferential standard in the absence of discretionary language, it expressly stressed that "[n]either general principles of trust law nor a concern for impartial decisionmaking . . . forecloses parties from agreeing upon a narrower standard of review." 489 U.S. at 115.

Allowing claims administrators to exercise discretion, when the parties have expressly contracted for it, is directly consistent with Congress' concern "not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans. . . . " *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (stating that ERISA's remedial scheme represents "a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans."). *See also Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1471 (9th Cir. 1993) ("a primary goal of ERISA was to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously.").

These flexible standards have been effective for employees. Until now, this Court's decision to delegate the function of weighing competing evidence to claims administrators has resulted in fulfillment of Congress' objective to "promote the interests of employees and their beneficiaries." *See Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983).

The rule adopted by the Ninth Circuit threatens to upset this flexible and successful legal landscape with a broad-brush rule based on erroneous stereotypes. As we explain in greater detail below, the close cases that give rise to hard decisions present an array of fact-sensitive

judgment calls that defy the sensible application of any broad-brush rule.

C. Fair Consideration Of The Facts Of Each Claim Defies A Broad-Brush Rule.

1. The Nature And Duration Of The Doctor-Patient Relationship Varies Greatly.

The Ninth Circuit stated that "treating physicians" "have a greater opportunity to know and observe the patient . . . " *Regula*, 266 F.3d at 1139. Depending on what the Ninth Circuit means by the term "treating physician," this is not necessarily true. A physician's opinion may be formed after only one visit, which may or may not even include a detailed examination. Certainly, it is not uncommon for patients to bring their disability insurance forms with them on their first visit to a specialist. In such instances, the "treating physician" differs from the examining physician only in that he offers a course or plan of treatment. He has no superior knowledge.

So where, then does one draw the line? Are two visits enough? And what if, as in this particular case, the doctor with the long-standing patient relationship, such as an internist, is relying on a consult from a specialist, and it is the specialist's opinion that is more relevant? *See Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 826 (9th Cir. 2002). Is the internist's opinion the opinion of a treating physician?

The answer is that in some cases the claims administrator will be inclined to place great weight on the internist's opinion, while in others it will not. It depends on the specific facts, the nature of the impairment, the quality of the opinion, whether the opinion comports with the symptoms, and so on.

2. The Expertise And Abilities Of The Doctors Varies Greatly.

Even putting to one side the extent of exposure to the patient that a doctor has had, one treating physician is not always like another. A dermatologist's opinion regarding the level of impairment caused by a brain tumor is usually entitled to little increased weight or deference. *See Regula*, 266 F.3d at 1153 (Brunetti, J., dissenting) (noting that denial letter explained that Committee found the reviewing-doctor's opinions more persuasive and expressed concerns about the "treating doctor's" lack of objectivity based on comments she made outside her area of expertise). But under the rule adopted by the Court of Appeals, claims administrators must accept that opinion or devote much time and expense developing "clear and convincing evidence" to rebut it.

3. The Amenability Of The Symptoms To Objective Analysis Varies Greatly.

With many conditions, opinions of impairment are predicated on subjective self-reporting of the claimant. Some of these conditions are themselves highly controversial in medical circles. *See* Bohr, T., *Fibromyalgia Syndrome and Myofascial Pain Syndrome, Do They Exist?*, Neurologic Clinics, Volume 13, Number 2, May 1995.

With elusive disorders of this sort, the very existence of the disability plan becomes a factor. Patients may be able to work with discomfort, but some would prefer not to do so. Confronted with such a situation, particularly one involving issues of stress and pain, the doctor may well conclude that, although he would not preclude work if the patient needs the income, he can support a claimed inability to work if the result is that the patient still gets income, and feels better. Helping the patient feel better is the doctor's job.

Indeed, in order to maintain an effective doctor/patient relationship, treating physicians must essentially accept their patients' complaints at face value, rather than seek to question or test them through independent analysis. *See Maniatty v. UNUMProvident Corp.*, 218 F.Supp. 2d 500, 504 (S.D.N.Y. 2002) ("[I]t was not unreasonable for the administrator to conclude that the only material reason the treating physicians were reaching their diagnoses was based on their acceptance of plaintiff's subjective complaints: *an acceptance more or less required of treating physicians*, but by no means required of the administrator.") (emphasis added). In these circumstances, a rule that requires deference to the treating physician's opinion is a rule that, in effect, requires deference to the claimant's stated opinion.

Mental disorders present their own peculiar problems in this regard. Although objective criteria may exist with respect to the *diagnosis* of mental disorders (*i.e.*, Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (DSM IV)), there are almost no such criteria designed to guide the assessment of occupational disability resulting from mental disorders. Treating practitioners frequently make disability assessments after brief initial interviews based almost exclusively on subjective reports of patients. And the treating doctor, by his very role, is often reluctant to challenge what the patient tells him. In fact, disbelief or skepticism by the doctor would impede the psychotherapeutic relationship, which is based in large part on trust. While a favorable opinion concerning disability will ensure another visit, an unfavorable opinion will most likely mark the end of the relationship.

A prudent claims administrator is aware of these real world factors. He therefore will consider, in questionable cases, seeking an independent opinion. He will look at factors such as, for example, whether the claimant appeared to have motives to want to work, or not to want to

work. A broad-brush rule that the favorable opinions of claimant's chosen practitioner must be given a burden shifting weight eliminates careful consideration of this type.

4. The Absence Or Presence Of Indicia Of Doctor-Bias Varies Greatly.

Many treating physicians call it straight even if they risk losing the patient. Others do not, for reasons that are not necessarily improper. A physician committed to curing the patient must consider the patient's best interests. *See* Dickman, R., *Bending the Rules to Get a Medication*, American Family Physician, Volume 61, Number 5, March 1, 2000, p. 2 ("The nature of the 'engagement with a patient' enjoins us to do everything we can to preserve or restore his or her health."). A physician may determine that although able to work, the patient's interest are better served by staying out of work and collecting disability, than by returning to a job the patient may well dislike. *See id.* ("When I acknowledge the special relationship I have with my patient, my openness to bending the truth in order to serve her direct interest is enhanced . . . "); Bigos, S.J., Battie, M.C., Spengler, D.M., et al.: *A Prospective Study of Work Perceptions and Social Factors Affecting the Report of Back Injury*, Spine, 16:1, 1991 (pre-existing job dissatisfaction is a predictor for disability). Disability determinations based on such considerations clearly take place. A recent study shows that 28% of physicians surveyed agreed with the statement that "in general it is ethical to 'game the system' for your patient's benefit." Wynia, M., Cummins, D., VanGeest, J., Wilson, I., *Physician Manipulation of Reimbursement Rules for Patients*, Journal of the American Medical Association, April 12, 2000, Vol. 283, No. 14, p. 1858. *See id.* at 1865 ("While insurance policies are contracts between patients and

insurers, our findings suggest that some physicians believe that strictly enforcing these contracts is contrary to their professional role as patients' agents and caregivers.") And this problem is exacerbated when a claims administrator has no direct way to know whether or not the physician in question is one of the 28% who believe that such tactics are acceptable.

Such physician bias is also sometimes evidenced by the timing and circumstances of the physician's retention. Many times patients visit doctor after doctor until they find one that will validate their complaints. *See* Bohr, *Fibromyalgia Syndrome and Myofascial Pain Syndrome, Do They Exist?*, *supra* at p. 380 (*citing* Fibromyalgia newsletter which urges sufferers to "avoid relationships with practitioners and physicians who cause you to doubt yourself. . . . If things don't work out, fire them and hire someone else more suited to your needs" and provides list of suggested practitioners); Aranoff, G., Feldman, J., Campion, T., *Management of Chronic Pain and Control of Long-Term Disability*, Occupational Medicine, Vol. 15, No. 4, October – December 2000, p. 759 ("Feeling disbelieved or discounted, [chronic pain] patients often go from one physician to the next looking for the one who 'will really listen and understand my pain.'").

A doctor retained after a disability claim has been made, or even after the initial claim has been denied, may be selected for her specialized expertise, or she may be selected because the claimant or his attorney understand that she is more likely to render a more favorable disability determination than her predecessors. Opinions of doctors selected for the purpose of supporting the diagnosis, or worse yet the disability claim, are entitled to less, not more weight.

The physician's association with claimant's counsel is also a factor in assessing bias. In *Regula*, the majority

found "far more troubling . . . the conflict of interest inherent when benefit plans repeatedly hire particular physicians as experts." 266 F.3d at 1143. This is an odd comment indeed. If a plan hires the same neurologist to review claims of back pain, and that neurologist applies consistent, medically-recognized standards causing him to find 90% of the claimants disabled, how is that troubling? On the other hand, what of the claimants' counsel who refers his clients to his chosen "treating physician" who finds the claimants almost always disabled and prescribes continuing treatment? The Ninth Circuit has ruled that, in all cases, an opinion from the latter must be met by "substantial evidence," and that a contrary opinion from the former will not suffice.

5. The Pertinence Of The Doctor's Knowledge To The Disability Issue At Hand Varies Greatly.

A physician otherwise perfectly qualified to diagnose a particular condition may not have inquired about what the claimant's job duties entail, let alone seek input from the employer. Likewise, such a physician may have no expertise or experience in determining how a particular sickness or injury impacts one's ability to perform those duties, relying instead on his instincts and the subjective reports of his patient. Yet that same physician may be totally willing to render an opinion on that topic at the request of his patient. Disability insurers frequently receive such opinions, and sometimes decide, depending on the circumstances, to defer to the competing view of their own qualified and experienced practitioner.

In sum, the significance and value brought to the table by a so-called "treating physician" varies depending on the circumstances of each case. Very often claims administrators do find the opinion of a treating physician to be very significant in making accurate disability determinations. The

courts, of course, rarely see these cases. Sometimes, though, especially in the close, disputed cases, the opinion of the so-called treating physician is not something that is persuasive to an experienced claims administrator.

II. THE NINTH CIRCUIT'S RULE WILL DECREASE CONSISTENCY AND UNIFORMITY IN BENEFIT DETERMINATIONS.

Employers expect benefit determinations to be consistent, such that one similarly situated employee is treated like another. Claims administrators achieve this consistency by selecting skilled medical professionals, who can review a large number of similar claims, develop expertise in matching conditions to work demands, and form consistent views over time. These professionals are also involved in assisting claimants with back-to-work programs, thus developing a sense of what people with certain conditions can and cannot do, and what accommodations can be made to allow them to work.

To adopt a rule that the opinions of so-called treating physicians must be deferred to, even in the face of a contrary medical opinion, will threaten claims administrators' ability to achieve consistent treatment of like cases. Benefits in cases involving subjective claims will turn, instead, on doctor-shopping by claimants. Consistency will decrease, costs will rise, and fewer employers will provide benefits great enough to tempt workers to look for ways to avoid having to return to work, harming those who truly cannot return.

Assessing the credibility of medical evidence on a case-by-case basis is reasonable, leads to consistent results for similar claims and has worked to the benefit of millions of employees since the enactment of ERISA. There is no reason to change the rule now.

III. THE "OPPORTUNITY" TO EXPLAIN AND REBUT THE TREATING PHYSICIAN'S OPINION DOES NOT SAVE THE RULE.

One possible response to the foregoing critique of the so-called treating physician rule is that the Ninth Circuit has not in fact held that the claims administrator must accept the position of the treating physician in all cases. Rather, the Ninth Circuit has left the door ajar, describing the so-called treating physician rule as one under which the claims administrator may reject the opinion of the treating physician if, and only if, the claims administrator gives "specific legitimate reasons for doing so that are based on substantial evidence in the record." *Regula*, 266 F.3d at 1140. Thus, perhaps "all" the Ninth Circuit has done is to construe its application of the treating physician rule as shifting to the claims administrator a "mere" burden of articulating why the claims administrator decided not to accept the opinion of the treating physician.

Such a defense of the treating physician rule in ERISA cases fails for three reasons.

A. The Rule's Presumption In Favor Of The Treating Physician Is Substantial.

First, as articulated by the Ninth Circuit, the rule in fact creates far more than a "mere" burden of explanation. Once the claims administrator believes that he has received an opinion from a doctor that might be deemed to qualify as an opinion of a treating physician, the claims administrator will have to pay for and obtain a second medical opinion unless he can offer "clear and convincing" evidence, in writing. *Regula*, 266 F.3d at 1140. Moreover, once the claims administrator obtains a second medical opinion, and even if the second medical opinion is directly contrary to that of the so-called treating physician, the claims administrator must follow the opinion of the

treating physician unless the claims administrator can "show by substantial evidence in writing why the opinion of the treating physician must be rejected." *Id.* The rule thus imposes, at a minimum, a burden to both explain and to rebut with something more than a competing medical opinion by a qualified doctor known to the administrator. The rule thus elevates the treating physician's opinion to a weighty presumption.

The weight of this presumption appears to be very substantial. In this case, the key issue was subjective, the medical condition on its face was amenable to workplace accommodation and/or medication, the administrator received a firm opinion from a qualified neurologist, the administrator offered the claimant two opportunities to have his physicians critique the independent examiner's opinion, and the claimant, who was represented by counsel, failed to do so. *See* App. to Petition for Certiorari, p. 34. Yet the Ninth Circuit concluded, as a matter of law, that such was a mere "scintilla" of evidence insufficient to outweigh the original opinions of the claimant's chosen, suddenly-mum doctors. *Nord*, 296 F.3d at 832. Under this rule, no adult with common degenerative disc disease who does not want to work, even at a sedentary job that allows frequent standing and stretching, ever need do so again as long as his or her employer establishes a disability plan with generous income replacement benefits. And if that is the result, fewer employers will sponsor and pay for such plans, harming the huge majority of disabled workers who are now able to obtain benefits. The Ninth Circuit's broad-brush distrust of claims administrators thus becomes the enemy of the great good Congress has wrought.

B. Deciding When The Rule Applies Will Spawn Collateral Litigation.

Second, no matter how one describes the treating physician rule, and even if one were to pretend that it simply shifts the burden of explanation, one still has to deal with resolving the definitional complexity of deciding when the rule applies. Must the physician upon whom the claimant relies have actually examined him? For how long must he have treated him? Does the burden to explain and rebut arise if the putative treating physician was retained by the claimant's counsel? What if the treating physician is actually opining on a matter of work demands or if the opinion rests on a simple subjective recitation of the claimant's self-reported symptoms? If the doctor is opining outside of his specialty, does the rule apply? Does the claims administrator have to explain why the rule does not apply (which would mean, apparently, that mere incantation of the rule by a claimant, whether applicable or not, would shift to the claims administrator a burden of explanation)? It will, at a minimum, impose a new burden of detailed explanation upon claims administrators and a substantive and substantial burden of persuasion as well.

C. The Rule Opens The Door For Courts To Apply More Presumptions To Other Kinds Of Evidence.

The logic behind such a burden-shifting rule leads down a long and expensive slope. If the Ninth Circuit distrusts independent doctors retained by claims administrators, then what will it next have to say about weighing the probative force of, for example, vocational evaluations submitted by claimants against those that are put forward by the employer? Will the claimant's substance abuse counselor trump a psychologist retained by the plan? Is a

neighbor's observations of apparent pain by the claimant more credible than that of the employer?

The facts of this case provide a preview of this slippery slope. The Ninth Circuit held that Black & Decker's rejection of the hypothetical conclusion of its own human resources representative, was "not only high-handed but also certainly some evidence of a conflict." *Nord*, 296 F.3d at 830. And this was despite the fact that, as noted by the District Court, the human resources representative "apparently lack[ed] any expertise or credentials in medicine, disability evaluation, and vocational evaluation," and "did not take into account plaintiff's prescription painkillers." Appendix to Petition for Certiorari, p. 34.

Under the new regime established by the Ninth Circuit, then, fact-sensitive, discretionary reviews will be replaced by literally years of litigation as courts seek to write out the full panoply of subsidiary rules to go with this new regulation.

IV. THIS CASE DOES NOT PROVIDE AN OPPORTUNITY TO REVISIT *FIRESTONE* BUT IF THIS COURT DOES SO IT SHOULD HOLD THAT THE NINTH CIRCUIT ERRED IN ITS INTERPRETATION OF THAT CASE.

The intrinsically related issues of "discretion" and "conflict of interest" present somewhat of a conundrum in this case. On the one hand, by requiring administrators to defer to "treating physicians," by applying a "presumptively void" conflict of interest test, and by holding that failure to follow the treating physician rule was evidence of conflict, the Court of Appeals voided the administrator's discretion entirely. In the abstract, then, the Court of Appeals' analysis invites an examination of *Firestone* and what this Court meant when it stated that a conflict of interest "must be weighed as a factor" in determining

whether the administrator abused his discretion. *See* 489 U.S. at 103.

On the other hand, this Court has not granted *certiorari* on the "conflict of interest" issue. Moreover, although the Ninth Circuit used a "conflict of interest" analysis to apply *de novo* review, the court did not remand in order for the district court to conduct such a *de novo* review. Instead, it held that "no reasonable trier of fact could conclude that Nord is not disabled." *Id.* Were that indeed the case, then the result would be the same irrespective of the standard of review. Thus, everything that the Ninth Circuit says in its opinion about the standard of review, and "conflict of interest," is irrelevant to its holding. Moreover, if this Court reverses the Ninth Circuit's application of the treating physician rule, then the principal asserted basis for finding a conflict of interest (failure to follow the treating physician rule) disappears.

Accordingly, based on the issue upon which this Court granted *certiorari*, and based on the ultimate holding by the Court of Appeals, the proper result is to maintain *Firestone* as a given and treat the "conflict of interest" issue as not properly raised. This Court should simply reverse the Court of Appeals' adoption of the treating physician rule and remand for further proceedings. In the event, nevertheless, that this Court chooses to examine the Ninth Circuit's interpretation of *Firestone*, it is clear that the interpretation is erroneous for the reasons set forth below.

A. The Court Of Appeals Impermissibly Eviscerated The Claims Administrator's Discretionary Right To Independently Weigh The Medical Evidence.

Despite the well-settled and firmly grounded legal landscape described above, whereby decisions concerning

the amount of weight to give medical evidence were made by claims administrators on a case-by-case basis, and without citing any evidence to the effect that this mode of analysis somehow failed to protect ERISA beneficiaries sufficiently, the Ninth Circuit has now dramatically changed the legal lay of the land.

By purporting to require administrators to weigh medical evidence in a compulsory manner in all cases involving so-called "treating physicians," the Court of Appeals' ruling eliminates the very discretion that the *Firestone* Court expressly held could be contracted by the parties through plan documents. 489 U.S. at 114. As explained above, with discretion comes the right to determine the credibility of evidence. The Ninth Circuit now purports to tell claims administrators how to perform that function, and where "treating physicians" are concerned, has strictly limited that right. This is contrary to *Firestone*.

B. The "Presumptively Void" Test Applied By The Court Of Appeals Is Invalid.

In *Firestone*, this Court held that "if a benefit plan gives discretion to an administrator . . . who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115. Since *Firestone*, the circuits have split in their interpretations of this language in the context of the proper standard to apply when the decision-maker is also the funding source. *See* Comment, *An Overview of the Inconsistency Among the Circuits Concerning the Conflict of Interest Applied in an ERISA Action With an Emphasis On The Eighth Circuit's Adoption of the Sliding Scale Analysis in Woo v. Deluxe Corporation*, 75 N.D. L. Rev. 815, 827-28 (1999).

The majority of circuits apply differing variations of a "sliding scale" test whereby courts adhere to the abuse of discretion standard but temper the amount of deference according to the degree of conflict under which the courts perceive the administrator to be operating. *See id.* at 832. The Ninth Circuit is among the minority of two circuits that apply a "presumptively void" test. *See id.* at 853-57. Under this test, a "heightened standard" applies where the decision-maker is also the funding source. *Id.* Under the heightened standard, if the claimant comes forth with "material, probative evidence" tending to show that the administrator's self-interest caused it to breach its fiduciary duty to the claimant, the burden shifts to the administrator to show that the conflict did not affect its decision. *Id.* at 857. If the administrator cannot rebut this presumption, it forfeits any discretion and the court reviews the decision *de novo*. *Id.*

There is, however, no reason to afford less deference or apply a "heightened standard" simply because the decision-maker is also the source of funds. In *Firestone*, the Third Circuit held that such an "inherently conflicted" fiduciary is not entitled to deference solely because the court viewed such a conflict as providing a disincentive for impartial decision-making. 828 F.2d 134 (3rd Cir. 1987) *aff'd in part and rev'd in part*, 489 U.S. 101. This Court rejected that rationale stating that "we do not rest our decision on the concern for impartiality that guided the Court of Appeals . . . " that "[n]either general principles of trust law nor a concern for impartial decisionmaking . . . forecloses parties from agreeing upon a narrower standard of review . . . " and that "if a benefit plan gives discretion to an administrator . . . who is operating under a conflict of interest, that conflict must be weighed as *a factor in determining whether there is an abuse of discretion*." 489 U.S. at 115 (emphasis added).

Moreover, ERISA specifically allows an employer to appoint its own officers to administer its plans even if the company is a party in interest. 29 U.S.C. § 1108(c)(3). *See Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995) (stating that Congress would have prohibited corporate officers from serving as claims administrators if it questions the ability of such persons to administer employer-created plans fairly). *See also Varity Corp. v. Howe*, 516 U.S. 489, 497 (1997) stating that Congress "expect[ed] that the courts will interpret [ERISA's] (. . . fiduciary standards) bearing in mind the special nature and purpose of employee benefit plans" and that while trust law may provide a "starting point" "courts may have to take account of competing congressional purposes" such as encouraging the formation of benefit plans). *Id.* at 497.

Finally, the marketplace itself provides substantial competing incentives for administrators to decide claims accurately. Simply put, employers cannot attract good employees and insurers cannot sell policies, if it is perceived that the benefits promised are illusory. *See Leahy*, 315 F.3d at 17 ("the structure of the Plan furnishes an incentive for MetLife to be unbiased in its handling of claims. This is telling, for courts should not lightly presume that a plan administrator is willing to cut off its nose to spite its face."); *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) ("Travelers can hardly sell policies if it is too severe in administering them); *Perlman v. Swiss Bank Corp.*, 195 F.3d 975, 981 (7th Cir. 1999) (Employers "offer fringe benefits such as disability plans in order to attract good workers, which they will be unable to do if promised benefits are not paid."). The UNUMProvident Companies' claims statistics (*supra*, p. 3) overwhelmingly demonstrate that there is no support for the notion that their staff is "any more 'partial' against applicants than are federal judges when deciding income tax cases." *See Perlman*, 195 F.3d at 983.

In sum, the mere fact of a so-called "inherent conflict" cannot serve to change the applicable deferential standard. The Ninth Circuit's "presumptively void" test presumes that Congress and this Court intended to limit the discretion of an employer like Black & Decker because it is likely to deny claims to protect its bottom line. These presumptions are all invalid and therefore so is the Ninth Circuit's test.

C. The Court Of Appeals' Holding That Failure To Follow The Treating Physician Rule Is Evidence Of A Conflict Constitutes A Circular Attempt To Get Around The Required Deferential Standard Of Review.

By holding that failure to apply the treating physician rule is material, probative evidence of a conflict of interest, the Court of Appeals collapsed the inquiry as to whether the claims administrator abused his discretion, with the inquiry as to whether the claims administrator should have any discretion at all. This was a clever, but circular and invalid end-run around the deferential standard mandated by *Firestone*.[2]

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[2] *Amici* are unaware of any circuit court that has held that simply by failing to grant deference to the opinion of a "treating physician," an administrator forfeits the discretion granted to it by the plan documents. In fact, at least three circuits have held that reliance on independent medical opinions (contrary to those of "treating doctors") removed any alleged taint of "conflict" thereby supporting review under a deferential standard. *Leahy v. Raytheon Co.*, 315 F.3d 15, 16 and n.4 (1st Cir. 2002) ("We are aware of no case holding that a plan administrator operates under a conflict of interest simply by securing independent medical advice . . . extrapolating from the available case law suggests the opposite conclusion."); *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 233-34 (4th Cir. 1997) (any conflict of interest "greatly mitigated" by reliance on independent roundtable); *Donato v. Metropolitan Life Ins.*

(Continued on following page)

Essentially, the court was able to obviate the abuse of discretion standard simply by substituting its own judgment for that of the claims administrator (which under an abuse of discretion standard, it cannot do). First, the court found a particular piece of evidence (treating physicians' opinions) more credible (*i.e.*, substituted its judgment for that of the administrator). Then, it created a presumption of taint by holding that failure to defer to that evidence signified a conflict of interest. The administrator, of course, could not rebut the presumption, nor could any administrator, having in the first instance failed to explain the reasons for not deferring. And thus, any discretion fell away, the standard of review was converted to *de novo*, and now the court was free to substitute its judgment for that of the administrator, deciding as a factual matter that the claimant was disabled (though purporting to use the summary judgment standard as a way to decide the issue itself rather than remanding to the district court).

The Court of Appeals thus paved the way for reviewing courts (whether district courts or courts of appeals) to entirely obviate the administrator's discretion any time they disagree with the manner in which the administrator exercised that discretion. And it does not stop with "treating physicians." As discussed above, if failing to defer to a treating physician is evidence of conflict, what prevents courts from holding that failing to defer to any other equally relevant piece of evidence also constitutes a conflict? That is exactly what the Court of Appeals did

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Co., 19 F.3d 375, 380, n.3 (7th Cir. 1994) (insurer's reliance on advice of independent physician rebutted any potential conflict). *Leahy*, in particular, is interesting because the First Circuit declined to adopt the treating physician rule even though one member of the unanimous panel, Judge Fletcher (sitting by designation), was the author of both *Regula* and *Nord*. *See* 315 F.3d at 20.

here by holding that rejection of the human resource representative's opinion was "high handed . . . [and] also certainly some evidence of a conflict." 296 F.3d at 830. Thus, again, the court stepped into the shoes of the claims administrator, decided which evidence was more credible, and used the administrator's contrary view on credibility (*i.e.*, the administrator's exercise of its discretion) to rob it of that very discretion granted by the plan documents and mandated by *Firestone*.

At the end of the day, the result here was that the claims administrator lost the discretion granted to him by the plan documents for no other reason than that the Ninth Circuit is unwilling to rely on an employer who voluntarily establishes a plan to administer it fairly. But again, as discussed above, such a result is contrary to *Firestone*, Congressional intent, and sound public policy.

To be sure, this Court has held that a conflict of interest must be "weighed as a factor in determining whether there is an abuse of discretion." *Firestone*, 489 U.S. at 115. While this phrase has caused confusion among the circuits, there can be no doubt that what the Court of Appeals did here bears no relation to any reasonable interpretation of that phrase.

Cases may arise where circumstances legitimately call into question the motivation of a claims administrator. And if the claimant can produce probative evidence that the decision was actually improperly motivated, it may be perfectly appropriate to consider those circumstances in determining whether the administrator has abused the discretion granted to him. *See Pari-Fasano v. Paul Revere*, 230 F.3d 415, 418-19 (1st Cir. 2000) (claimant bears the burden of producing evidence of improper motivation). But this is not such a case.

A so-called "inherent conflict," without more, cannot provide a basis upon which to depart from the abuse of

discretion standard. *See id.* And failing to defer to any arbitrarily selected piece of evidence solely because the court has deemed it more credible cannot provide the necessary evidence of improper motivation. If it could, then there would be no deferential standard notwithstanding *Firestone*.

The Court of Appeals' ruling with respect to conflict of interest was erroneous. This Court should reject it.

CONCLUSION

For the reasons stated above, this Court should reverse the ruling below.

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Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

BRIEF OF THE NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES AS *AMICUS CURIAE* IN SUPPORT OF THE RESPONDENT

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INTEREST OF *AMICUS CURIAE* NOSSCR[1]

The National Organization of Social Security Claimants' Representatives (NOSSCR) is a non-profit corporation. NOSSCR members represent claimants in administrative proceedings for claims for federal benefits – primarily disability benefits – under Titles II and XVI of the Social Security Act, 42 U.S.C. §§ 401-434, 1381-1383f, and represent in civil litigation plaintiffs for Social Security benefits whose claims were denied administratively. NOSSCR members commonly represent claimants not only for Social Security benefits, but also for benefits under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq*. As *amicus curiae*, we present to the Court the interests both of our members who represent ERISA claimants and those ERISA claimants themselves. Our members and their clients have an interest in the full and fair review of claims for ERISA benefits. NOSSCR has filed *amicus* briefs in several prior cases to assist the Court by presenting the viewpoints of our members and their clients.

Additionally, NOSSCR members have vast experience with the well-established "treating physician rule" of Social Security law. This case involves the application of a treating physician rule in the ERISA context. We seek to assist the Court in its analysis of a treating physician rule

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[1] The parties have consented to the filing of this *amicus* brief in support of Respondent. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the *amicus curiae*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

in the ERISA context based on our experience with the treating physician rule of Social Security law.

SUMMARY OF ARGUMENT

Judicial review of a plan administrator's denial of ERISA disability benefits typically involves consideration of medical opinions from treating and non-treating physicians. Neither the ERISA statute nor ERISA regulations explain how a court should consider various medical opinions when ruling on a challenge to a plan administrator's denial of ERISA disability benefits. Given this void and the necessity to consider medical opinions, the Ninth Circuit reasonably adopted the treating physician rule of Social Security law as part of the common law of ERISA. Social Security law has a mature, flexible treating physician rule well-suited to guide judicial review of a plan administrator's denial of ERISA disability benefits.

Petitioner purportedly identifies serious defects in Social Security's treating physician rule. For example, Petitioner contends that the rule does not take into account a physician's specialty. On the contrary, Social Security's treating physician rule requires consideration of a physician's specialty. Social Security's treating physician rule does not have the defects Petitioner alleges.

Petitioner maintains that Social Security's treating physician rule is inappropriate for ERISA because, unlike Petitioner's ERISA plan, Social Security does not define disability in terms of past work, and because, unlike ERISA, the burden of persuasion in Social Security cases is not on the claimant. Petitioner thereby mischaracterizes Social Security's definition of disability and burden of persuasion.

Petitioner also objects generally to a treating physician rule on the ground that it is incompatible with deferential judicial review, including deference to a factfinder's resolution of a conflict in the medical evidence. The experience of the lower courts reviewing administrative denials of Social Security disability benefits under 42 U.S.C. § 405(g) refutes this objection. For more than a decade, the lower courts have applied Social Security's treating physician rule when undertaking deferential substantial evidence review of administrative denials of Social Security disability benefits.

For these reasons, the Ninth Circuit correctly adopted Social Security's treating physician rule as the common law of ERISA for judicial review of a plan administrator's denial of ERISA disability benefits.

ARGUMENT

I. Instead Of Trying To Identify Anew In Each ERISA Case Principles To Guide The Consideration Of Medical Opinions, The Ninth Circuit Reasonably Adopted The Mature, Flexible Treating Physician Rule From Social Security Law

Respondent must satisfy the definition of disability set forth in the Black & Decker Disability Plan (Plan) in order to receive ERISA disability benefits. The Plan defines disability in terms of an employee's medical conditions and his ability to work. (L. 20.) Under the Plan, an employee is disabled during the first thirty months of disability if he cannot perform his regular occupation due to his mental and/or physical conditions. (L. 20.) Therefore, consideration of medical opinions is intrinsic both to the determination of disability by a plan administrator

and to judicial review of a plan administrator's denial of benefits. The same is true in the context of disability benefits under the Social Security Act. Consideration of medical opinions is intrinsic both to the administrative determination of claims for Social Security disability benefits, *see* 42 U.S.C. § 423(d), and to judicial review of administrative denials of claims for those benefits, *see* 42 U.S.C. § 405(g). Faced with the recurrent issue of how to consider medical opinions on judicial review of denials of ERISA disability benefits, the Ninth Circuit reasonably adopted the "treating physician rule" from Social Security law.

Although the ERISA statute does not address this recurrent issue, the Courts of Appeals are authorized to craft a common law for ERISA to fill the statutory void. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989). Inasmuch as the Secretary of Labor did not anticipate in the 2000 regulations this recurrent issue of how to weigh conflicting medical opinions, it is necessary for the courts to provide a reasonable framework for dealing with this common situation. Nothing in the Secretary of Labor's implementing regulations (the current version of which does not specifically apply to the instant case, *see* 65 Fed. Reg. 70,246 (2000)) provides any guidance in this area.[2] Hence, contrary to the position of the Solicitor General, it cannot reasonably be argued that judicial imposition of a treating physician rule interferes with the "primary jurisdiction" of the Secretary of Labor. (U.S. Br. 11.) The Ninth Circuit reasonably filled the

[2] Addressing a different concern, the Department of Labor's 2000 regulations state that an ERISA plan administrator shall consult with a health care professional. 65 Fed. Reg. 70,269 (2000); 29 C.F.R. § 2560.503-1(h)(3)-(4) (2002).

statutory and regulatory void with the mature, flexible treating physician rule from Social Security law. (Petition App. 13.) *Cf. Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 695 n.11 (7th Cir. 1992) ("Although the standards used in adjudicating social security cases are not applicable under ERISA, the guiding principles developed in those cases may be 'instructive' in ERISA cases."). By adopting the mature, flexible treating physician rule from Social Security law, the Ninth Circuit eliminated the need to decide anew in each case the appropriate rules for weighing medical opinions. Instead, guided by the treating physician rule, a court can focus on the facts of a particular ERISA case to determine on *de novo* or deferential judicial review whether the court should overturn the denial of disability benefits. Utilizing the treating physician rule from Social Security law for judicial review of denials of ERISA disability benefits thus promotes principled decisionmaking and judicial economy. Accordingly, this Court should approve of the application of a treating physician rule in ERISA cases without prejudice to the right of the Secretary of Labor to address this matter by regulation. *Cf. Schisler v. Sullivan*, 3 F.3d 563, 567-69 (2d Cir. 1993) (*Schisler III*) (holding that Social Security's new regulatory treating physician rule superseded prior Second Circuit treating physician caselaw).

II. Social Security's Treating Physician Rule Is A Response To The Need To Evaluate Medical Opinions When Deciding Disability Claims Administratively And When Undertaking Judicial Review Of Denied Claims

Because disability under the Social Security Act is based on a claimant's medical condition, *see* 42 U.S.C. § 423(d), Social Security Administration (SSA) adjudicators must

evaluate medical opinions from treating and non-treating physicians. For the same reason, federal courts must consider medical opinions when deciding whether to affirm or reverse administrative denials of Social Security disability benefits. *See* 42 U.S.C. § 405(g). By the mid-1980s, almost all of the Courts of Appeals had adopted a treating physician rule for Social Security cases. *See* Rachel Schneider, *A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. Chi. L. Sch. Roundtable 391, 396-400 (1996) (surveying caselaw). Under the rule, more weight is generally owed to the opinion of a treating physician than a non-treating physician because a treating physician has more opportunity to observe and know his patient and because the treating physician is responsible for providing medical care. *See, e.g.*, *Murray v. Heckler*, 722 F.2d 499, 501-02 (9th Cir. 1983). Unlike other Circuits, the Second Circuit's rule in the 1980s was absolutist, stating that a treating physician's opinion was sometimes "binding." *Schisler v. Bowen*, 851 F.2d 43, 47 (2d Cir. 1988) (*Schisler II*). In 1991, the Agency issued a regulatory treating physician rule for three reasons: to announce that independent of caselaw a treating physician rule is appropriate; to summarize its agreement with caselaw principles; and to accept the Second Circuit's invitation to set forth a nationwide rule. *See* 56 Fed. Reg. 36,934 (1991); *see also* 20 C.F.R. § 404.1527 (2002)[3] (codifying as amended SSA's treating physician rule) (set forth in Appendix of this Brief).

[3] The regulations for claims under Title II of the Social Security Act are at 20 C.F.R. Part 404. We do not cite parallel regulations for claims under Title XVI of the Social Security Act at 20 C.F.R. Part 416.

In *Schisler III*, the Second Circuit held that the 1991 regulations superseded prior Second Circuit law. 3 F.3d at 569. Today, other Circuits cite interchangeably their caselaw and the 1991 regulations.[4] Petitioner argues that the Ninth Circuit "does not follow the SSA rule, even in SSA cases." (Pet. Br. 20 (*citing Morgan v. Commissioner of Social Security Admin.*, 169 F.3d 595, 600, 601 (9th Cir. 1999); *Lester v. Chater*, 81 F.3d 821, 831-32 (9th Cir. 1995); *Magallanes v. Bowen*, 881 F.2d 747, 750 (9th Cir. 1989)).) By this, Petitioner means that the Ninth Circuit utilizes its own caselaw treating physician rule instead of 20 C.F.R. § 404.1527 (2002). On the contrary, the Ninth Circuit follows 20 C.F.R. § 404.1527 (2002) as well as its caselaw. *See Edlund v. Massanari*, 253 F.3d 1152, 1157 (9th Cir. 2001) (*citing* 20 C.F.R. § 404.1527).[5] Because there is no substantive difference between Ninth Circuit caselaw and SSA regulations, the Ninth Circuit correctly

[4] *See, e.g.*, *Plummer v. Apfel*, 186 F.3d 422, 429 (3d Cir. 1999) (citing caselaw and 1991 regulations); *Craig v. Chater*, 76 F.3d 585, 590 (4th Cir. 1996) (same); *Loza v. Apfel*, 219 F.3d 378, 395 (5th Cir. 2000) (same); *Walters v. Commissioner of Social Security*, 127 F.3d 525, 529-30 (6th Cir. 1997) (same); *Clifford v. Apfel*, 227 F.3d 863, 870 (7th Cir. 2000) (same); *Nelson v. Sullivan*, 966 F.2d 363, 367-68 (8th Cir. 1992) (same); *Castellano v. Secretary of Health and Human Servs.*, 26 F.3d 1027, 1029 (10th Cir. 1994) (same); *Lewis v. Callahan*, 125 F.3d 1436, 1440 (11th Cir. 1997) (same).

[5] *See also Holohan v. Massanari*, 246 F.3d 1195, 1202, 1205, 1207 (9th Cir. 2001) (*citing* 20 C.F.R. § 404.1527); *Regennitter v. Commissioner of Social Sec. Admin.*, 166 F.3d 1294, 1299 (9th Cir. 1999) (same); *Lester*, 81 F.3d at 832-33 (same); *Smolen v. Chater*, 80 F.3d 1273, 1285, 1288 (9th Cir. 1996); *Gomez v. Chater*, 74 F.3d 967, 971 (9th Cir. 1996) (same); *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995) (*citing* 20 C.F.R. § 416.927).

cites interchangeably its own caselaw and SSA regulations.[6] Although Ninth Circuit caselaw and SSA's regulations are the same, we generally discuss below Ninth Circuit caselaw and SSA's regulations separately, demonstrating that there is no substantive difference between Ninth Circuit caselaw and SSA's regulations and that even if Ninth Circuit caselaw were different from SSA's regulations, both Ninth Circuit and SSA law meet Petitioner's objections to a treating physician rule.

III. The Mature, Flexible Treating Physician Rule Of Social Security Law Meets Petitioner's Objections

A. A Treating Physician Rule Accounts For Specialization, Training, And Experience

Petitioner objects to a treating physician rule because it places an "almost insurmountable burden on the plan administrator who believes that the treating physician's opinion is erroneous." (Pet. Br. 45.) As a main example arguing against a treating physician rule, Petitioner asserts that a plan administrator would have a great and difficult burden refuting a podiatrist's opinion that a claimant was disabled by throat cancer. (Pet. Br. 45; *see also id.* 14-15, 29 (stating that a treating physician rule does not take into account a physician's training and experience).) This example is not a serious challenge to a treating physician rule. Under the Ninth Circuit's treating physician rule, as well as SSA's treating physician rule, the specialty of a physician must be considered when

[6] The Solicitor General does not allege that any Ninth Circuit decision is inconsistent with the 1991 regulations.

evaluating the physician's opinion. *See Smolen*, 80 F.3d at 1285 ("the opinions of a specialist about medical issues related to his or her area of specialization are given more weight than the opinions of a nonspecialist."); 20 C.F.R. § 404.1527(d)(5) (2002) ("We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.").[7] Similarly, under the Ninth Circuit's and SSA's treating physician rules, the nature of a podiatrist's treating relationship with a claimant as well as the podiatrist's clinical findings would be taken into account and would likely provide solid grounds to reject the podiatrist's opinion about throat cancer. *See Burkhart v. Bowen*, 856 F.2d 1335, 1139 (9th Cir. 1988) (ratifying rejection of treating physician's opinion unsupported by "medical findings, personal observations or test reports"); 20 C.F.R. § 404.1527(d)(2)(ii) (2002) ("For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain."); 20 C.F.R. § 404.1527(d)(3) (2002) ("The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion."). In fact, an ALJ or plan administrator would normally be justified in dismissing out of hand a podiatrist's opinion about a claimant's disability due to throat

[7] *See also Singh v. Apfel*, 222 F.3d 448, 452 (8th Cir. 2000) (specialist's opinion is generally owed more weight); *Mason v. Shalala*, 994 F.2d 1058, 1066-67 (3d Cir. 1993) (same); *Moore v. Sullivan*, 919 F.2d 901, 905 (5th Cir. 1990) (same).

cancer. *Cf.* 20 C.F.R. § 404.1513(a)(4) (2002) (acknowledging licensed podiatrists as "acceptable" medical sources only "for purposes of establishing impairments of the foot, or foot and ankle"); *Sobolewski v. Apfel*, 985 F. Supp. 300, 312 (E.D. N.Y. 1997) (similar).

B. Treating Physicians Provide Opinions That Support And Detract From Claims Of Disability

Petitioner maintains that the Ninth Circuit's treating physician rule "effectively puts a 'thumb on the scale' in favor of the claimant. . . . " (Pet. Br. 47.) A treating physician rule is not a one-sided rule in favor of claimants. Treating physicians commonly provide opinions that are probative evidence that their patients do *not* satisfy the relevant legal standard of disability. *See Osenbrock v. Apfel*, 240 F.3d 1157, 1165 (9th Cir. 2001) (affirming denial of benefits based on treating physician's opinion); *Moncada v. Chater*, 60 F.3d 521, 523 (9th Cir. 1995) (same); *Matthews v. Shalala*, 10 F.3d 678, 680-81 (9th Cir. 1993) (same); *Curry v. Sullivan*, 925 F.2d 1127, 1129 (9th Cir. 1991) (same).[8]

Treating physicians routinely report not only that their patients can work – perhaps with restrictions such

[8] *See also Buxton v. Halter*, 246 F.3d 762, 775 (6th Cir. 2001) (affirming denial of benefits based on treating physician's opinion); *Shramek v. Apfel*, 226 F.3d 809, 814-15 (7th Cir. 2000) (same); *DeChirico v. Callahan*, 134 F.3d 1177, 1184 (2d Cir. 1998) (same); *Jones v. Department of Health and Human Servs.*, 941 F.2d 1529, 1533 (11th Cir. 1991) (same); *Griego v. Sullivan*, 940 F.2d 942, 945 (5th Cir. 1991) (same); *Davis v. Secretary of Health and Human Servs.*, 915 F.2d 186, 189 (6th Cir. 1990) (same); *Gossett v. Bowen*, 862 F.2d 802, 807 (10th Cir. 1988) (same).

as a limitation on lifting heavy objects – but also that their patients *should* work. *See, e.g., Richardson v. Perales*, 402 U.S. 389, 391 (1971) (treating physician "advised that [the claimant] return to work"). In fact, the very purpose of much medical treatment is to restore a claimant's ability to work. Petitioner assumes without empirical or rational basis that treating physicians see themselves as protecting their patients from the workforce instead of helping their patients reach their maximum work capacities and continue or renew productive lives in the workforce.

Along the same lines, Petitioner asserts that the Ninth Circuit's treating physician rule "assumes that there is only one treating physician's opinion," (Pet. Br. 28), and cannot function reasonably if opinions from more than one treating physician conflict (Pet. Br. 29). Neither the Ninth Circuit's treating physician rule nor SSA's assumes that a claimant has only one treating physician. And both rules handle easily cases with opinions, including conflicting opinions, from more than one treating physician. *See Holohan*, 246 F.3d at 1201-05 (applying Ninth Circuit law and 20 C.F.R. § 404.1527 in case with more than one treating physician); *Magallanes*, 881 F.2d at 751-55 (applying Ninth Circuit law while resolving conflicting opinions from more than one treating physician).[9] In fact, in a *typical* disability case there are a series of opinions about various conditions from several treating physicians such as a treating orthopedist and a treating psychiatrist. *See, e.g., Perales*, 402 U.S. at 390-408 (two

[9] *See also Buxton*, 246 F.3d at 773-75 (ALJ reasonably weighed the opinions of several treating sources); *Wolfe v. Shalala*, 997 F.2d 321, 325-26 (7th Cir. 1993) (same).

treating physicians, five one-time examining physicians, and one non-examining physician). If it were true that a treating physician rule cannot reasonably be applied when there is more than one treating physician, the Courts of Appeals and SSA would have abandoned the treating physician rule years ago.

C. A Treating Physician Rule Accounts For Differences Between Treating Physicians

In Petitioner's view, the Ninth Circuit's treating physician rule has serious infirmities. According to Petitioner, in the Ninth Circuit the opinion of a physician who "'treated' a patient one time is afforded the same weight as that of a physician who has been treating the patient through the entire course of his impairment." (Pet. Br. 28.) The Ninth Circuit's rule allegedly does not take into account "the length of time" a physician has treated a claimant. (Pet. Br. 14.) The Ninth Circuit's treating physician rule is not so simple-minded and irrational. Instead, the Ninth Circuit's treating physician rule permits reasoned evaluation of a treating physician's opinion based on the extent of the treating relationship. *See, e.g.*, *Lewis v. Apfel*, 236 F.3d 503, 517 (9th Cir. 2001) (addressing the precise extent of a treating physician's contact with a claimant); *Andrews*, 53 F.3d at 1040 (rejecting claimant's argument that a psychologist who examined him four times but did not treat his condition was a treating source); *Matney ex rel. Matney v. Sullivan*, 981 F.2d 1016, 1020 (9th Cir. 1992) (holding that ALJ properly gave less weight to opinion of a treating physician who examined

the claimant only once).[10] The regulations are no different. *See* 20 C.F.R. § 404.1527(d)(2) (2002) (evaluating treating physician opinions based on the "[l]ength of the treatment relationship," the "frequency of examination," and the "[n]ature and extent of the treatment relationship"); 20 C.F.R. § 404.1502 (2002) (defining "treating source" as a physician or psychologist who had or has an "ongoing treatment relationship" with a claimant).

D. A Treating Physician Rule Responds To Allegations Of Advocacy And Bias

Petitioner contends that a treating physician rule is unwarranted because the rule does not account for a treating physician's presumed advocacy for his patient (by falsifying medical records and opinions) and presumed bias against his patient working. (Pet. Br. 29-33.) But Petitioner fails to address how the treating physician rule actually deals with allegations of advocacy or bias.

The Ninth Circuit has considered several times whether a treating physician's opinion may be rejected or given less weight on the ground that a claimant asked his treating physician to provide an opinion to obtain private

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[10] *See also White v. Barnhart*, 287 F.3d 903, 908 (10th Cir. 2001) (approving giving less weight to the opinion of a treating physician whose treatment relationship was "relatively brief"); *Schaal v. Apfel*, 134 F.3d 496, 504 (2d Cir. 1998) (noting that the relevance of a treating physician's opinion depends on the length of the treatment); *Diaz v. Shalala*, 59 F.3d 307, 314-15 (2d Cir. 1995) (ALJ properly gave less weight to the opinion of a treating specialist who had only examined the claimant several times); *Mason*, 994 F.2d at 1067 (ALJ erroneously implied that a physician who examined the claimant once was a treating physician).

or public disability benefits. The Ninth Circuit's treating physician rule has evolved so that it is able to evaluate reasonably allegations of advocacy or bias based on facts in particular cases instead of assumptions that treating physicians are deceitful. In *Saelee v. Chater*, 94 F.3d 520 (9th Cir. 1996), the Ninth Circuit affirmed an ALJ's rejection of a treating physician's opinion on the ground that the treating physician attempted to assist the claimant "in obtaining social security benefits." *Id.* at 522. The ALJ correctly found that the treating physician relied too heavily on the claimant's subjective statements and that an objective basis for the treating physician's opinion was lacking. *Id.* at 523. Later, in *Reddick v. Chater*, 157 F.3d 715 (9th Cir. 1998), the Ninth Circuit clarified that a treating physician's opinion could not be dismissed merely because the physician was asked to provide an opinion: "[I]n the absence of other evidence to undermine the credibility of a medical report, the purpose for which the report was obtained does not provide a legitimate basis for rejecting it." *Id.* at 726. Petitioner thus could have challenged the opinions of Respondent's treating physicians *within the treating physician rule itself*. But within the treating physician rule, Petitioner needed *evidence*, not assumptions, to show that the opinions of Respondent's treating physicians were unsupported and incredible. *Id.*[11]

As a related matter, Petitioner seems to argue that the Seventh Circuit (correctly) presumes in Social Security cases that a claimant's treating physician is a partisan

[11] *See also Frey v. Bowen*, 816 F.2d 508, 515 (10th Cir. 1987) (finding that ALJ did not cite any evidence to support allegation that a family physician "naturally advocates his patient's cause").

advocate for finding his patient disabled: "'The patient's regular physician may want to do a favor for a friend and client, and so the treating physician may too quickly find disability.'" (Pet. Br. 32 (*quoting Stephens v. Heckler*, 766 F.2d 284, 289 (7th Cir. 1985)).) In *Micus v. Bowen*, 979 F.2d 602 (7th Cir. 1992), the Seventh Circuit clarified that its decisions in *Stephens* and another case[12] do "not create a presumption of bias in a treating physician's disability opinion; the cases recognize only the ALJ's ability as a trier of fact to consider a physician's possible bias." *Id.* at 609. Furthermore, the Seventh Circuit does not understand *Stephens* as inconsistent with a treating physician rule: the Seventh Circuit cites *Stephens* along with SSA's regulations when evaluating medical opinions. *See Dixon v. Massanari*, 270 F.3d 1171, 1177 (7th Cir. 2001) (*citing Stephens*, 766 F.2d at 289, *and* 20 C.F.R. § 404.1527); *Butera v. Apfel*, 173 F.3d 1049, 1056 (7th Cir. 1999) (same); *Books v. Chater*, 91 F.3d 972, 979 (7th Cir. 1996) (same).

E. A Treating Physician Rule Penalizes Malingering

Petitioner believes that the treating physician rule places an adjudicator, plan administrator, and reviewing court at the mercy of a malingering claimant and his corrupt treating physician conspiring with the malingerer to obtain undeserved benefits.[13] (Pet. Br. 25, 32.) Petitioner's belief is unfounded. The treating physician rule does not allow a malingering claimant to obtain benefits

[12] *Reynolds v. Bowen*, 844 F.2d 451 (7th Cir. 1988).

[13] Petitioner does not assert that Respondent himself is malingering. (Pet. Br. 1-48.)

by misleading his treating physician or conspiring with his treating physician to obtain benefits fraudulently. Instead, when there is evidence that a treating physician's opinion is not based on clinical findings but on a claimant's volitional misrepresentation, the treating physician's opinion should be discounted. *See Edlund*, 253 F.3d at 1157 (affirming rejection of treating physician's opinion when treating physician was unaware that the claimant exaggerated his complaints to seek pain medication); *Sandgathe v. Chater*, 108 F.3d 978, 980 (9th Cir. 1997) (affirming rejection of treating physician's opinion when claimant's "psychological problems may have been volitional"); *Brawner v. Secretary of Health and Human Servs.*, 839 F.2d 432, 433-34 (9th Cir. 1988) (affirming rejection of treating physician's opinion because it was based on claimant's unreliable statements); 20 C.F.R. § 404.1527(d)(3) (2002) ("The more a medical source presents relevant evidence to support an opinion, *particularly medical signs and laboratory findings*, the more weight we will give that opinion.") (emphasis added).[14]

F. Non-Lawyers And Lawyers Alike Can Apply A Treating Physician Rule

According to Petitioner, a treating physician rule should not be applied in the ERISA context because a "lay ERISA plan administrator" lacks the training of an SSA

[14] *See also Mastro v. Apfel*, 270 F.3d 171, 178 (4th Cir. 2001) (ALJ properly rejected treating physician's opinion when the treating physician's "diagnosis was based largely upon the claimant's self-reported symptoms"); *Craig*, 76 F.3d at 590 (ALJ properly rejected treating physician's conclusory opinion based on claimant's subjective complaints).

ALJ and thus, supposedly, lacks the training and ability to apply a treating physician rule. (Pet. Br. 21.) Petitioner misunderstands SSA's administrative process. The SSA uses a four-tier administrative process in which a *de novo* hearing before an ALJ is the third step. *See* 20 C.F.R. § 404.900 (2002) (describing four tiers); *Heckler v. Day*, 467 U.S. 104, 106-107 (1984) (same). At the first and second tiers of the administrative process, non-lawyer "disability examiners"[15] make disability determinations applying the same treating physician rule as ALJs at the third tier.[16] Just as non-lawyer SSA disability examiners can apply a treating physician rule, lay ERISA plan administrators can apply a treating physician rule.

For a similar reason, Petitioner's allegation that a treating physician rule would require plan administrators "to engage legal counsel to review their benefit denials" is baseless. (Pet. Br. 14.) Nothing in the Ninth Circuit's treating physician rule or SSA's treating physician rule is

[15] Program Operations Manual System (POMS) DI 24501.005 (The Disability Determination Services (DDS) Disability Examiner's (DE's) Role In the Determination Process), *at* http://policy.ssa.gov/poms.nsf/poms?OpenView; *see also Washington State Dep't of Social and Health Servs. v. Guardianship Estate of Keffeler*, 123 S. Ct. 1017, 1025-26 (2003) (noting that the POMS warrants respect under *Skidmore v. Swift & Co.*, 323 U.S. 134, 139-140 (1944)).

[16] *See* 20 C.F.R. § 404.1502 (2002) (regulations apply to all levels of adjudication); 20 C.F.R. § 404.985(a) (2002) (adverse caselaw applies to all levels of adjudication); POMS DI 24515 (Specific Medical Evaluation Instructions) (instructions to disability examiners to follow the regulatory treating physician rule).

In Fiscal Year 2000, disability examiners made 1,988,425 determinations. Social Security Advisory Bd., *Disability Decision Making: Data and Materials* (Jan. 2001), at Chart 67, *at* http://www.ssab.gov/chartbookB.pdf.

so arcane or technical that it cannot be readily mastered by a plan administrator. Any plan administrator with the ability to understand and effectuate an ERISA benefits plan surely has the ability to understand and apply a treating physician rule. (*See* L. 15-30 (Black & Decker's sixteen-page disability plan).)

G. Petitioner Mischaracterizes SSA's Disability Programs

As justification for not applying in the ERISA context the Ninth Circuit's treating physician rule from Social Security law, Petitioner purports to identify major differences between SSA's definition of disability and Petitioner's definition of disability in its ERISA plan. (Pet. Br. 23.) Petitioner's argument is based on a mischaracterization or misunderstanding of SSA's disability program.

1. The Plan *And* SSA Define Disability In Terms of Past Work

Petitioner argues that a "decision by a plan administrator that an employee is disabled from *his own occupation* is entirely different than an ALJ's decision in an SSA case that a person is disabled from 'any substantial gainful activity.'" (Pet. Br. 22-23 (emphasis in original) (*quoting* 20 C.F.R. § 416.927(a)(1) (2002)).) This is incorrect. The Black & Decker Disability Plan has two definitions of disability. For the first thirty months, a claimant is disabled if he cannot perform his "regular occupation." (Petition App. 3; L. 20.) Beginning with the thirty-first month, disability is defined as the "complete inability (whether physical and/or mental) of a participant to engage in any gainful occupation." (Petition App. 3; L. 20.) This case involves a claim of disability during the first thirty months. (Pet. Br. 3.) The

plan's definition of disability during the first thirty months as a claimant's inability to perform his "regular occupation" is virtually identical to step four of SSA's well-known five-step sequential evaluation, for which the test is whether a claimant can do his "past relevant work":

> Your impairment(s) must prevent you from doing past relevant work. If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment(s), we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled.

20 C.F.R. § 404.1520(e) (2002) (step four);[17] *see also Bowen v. Yuckert*, 482 U.S. 137, 141-42 (1987) (summarizing sequential evaluation). Step four is the regulatory expression of the Social Security Act's provision that a claimant is not disabled if he can perform his "previous work." 42 U.S.C. § 423(d)(2)(A).

Petitioner argues that the "own occupation," i.e., regular occupation, disability test of the Black & Decker Disability Plan "requires knowledge and information about that occupation," while SSA's test does not. (Pet. Br. 23.) On the contrary, when SSA determines at step four whether a claimant can do his past relevant work, SSA gathers information about the mental and physical demands of that occupation. *See* Social Security Ruling (SSR)

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[17] The Court granted this Term the Solicitor General's petition for a writ of certiorari to review the Third Circuit's construction of step four. *Thomas v. Commissioner of Social Security*, 294 F.3d 568 (3d Cir. 2002), *cert. granted*, 71 U.S.L.W. 3390 (U.S. Feb. 24, 2003) (No. 02-763).

82-62;[18] *see also Pinto v. Massanari*, 249 F.3d 840, 845 (9th Cir. 2001) (applying SSR 82-62); *Winfrey v. Chater*, 92 F.3d 1017, 1024 (10th Cir. 1996) (same). Determining whether a claimant can do his past relevant work at step four necessarily requires knowledge of the demands of that past work.

Petitioner's underlying contention based on a plan administrator's need to know about the demands of a claimant's regular occupation – and an SSA adjudicator's supposed lack of need to know about demands of past work – appears to be that a treating physician's opinion is worthless because the treating physician is unfamiliar with the demands of the claimant's regular occupation. (Pet. Br. 23.) Petitioner's argument is ill-founded.

First, a claimant or plan administrator would simply need to provide a treating physician with relevant facts about a claimant's regular occupation to ensure that the treating physician addressed the claimant's ability to do his regular occupation. Petitioner assumes that the treating physician not only lacks relevant information about the claimant's regular occupation, but also that he cannot be provided with and assimilate that information. Petitioner's argument is not an argument against a treating physician rule. It is merely a good reason to provide the treating physician with the relevant information and to ask the treating physician relevant questions.

Second and more significantly, a treating physician can provide an opinion relevant to a determination of

[18] At http://www.ssa.gov/OP_Home/rulings/. Social Security Rulings announce agency-wide policy, and are binding on agency adjudicators. 20 C.F.R. § 402.35(b) (2002).

whether the claimant can do his regular occupation (past work) even if the treating physician knows nothing about the claimant's regular occupation. For example, if a treating physician opines that a claimant cannot lift more than five pounds and if the claimant's regular occupation requires lifting more than five pounds, the treating physician's opinion is evidence that the claimant cannot do the lifting that his regular occupation requires. Here, Respondent's treating physician Dr. Hartman opined that Respondent could not lift more than five pounds (L. 53), and Respondent's regular occupation as a material planner required lifting up to twenty pounds (L. 143). Therefore, Dr. Hartman's opinion was evidence that Respondent could not do the lifting that his regular occupation of material planner required. Thus, Petitioner's criticism of Dr. Hartman as not knowing "the essential functions of the position of a material planner" misses the point. (Pet. Br. 35.) Once Dr. Hartman specified Respondent's functional limitations (L. 53), it became a straightforward task to compare those limitations to the known requirements of Respondent's regular occupation as a material planner (L. 143). For the same reason, Petitioner's allegation that Dr. Hartman's opinions were not relevant to ascertaining whether Petitioner could work as a material planner has no basis in fact or logic. (Pet. Br. 45.) Petitioner's objections to the treating physician rule do not withstand even superficial review.[19]

[19] Petitioner suggests, "Some persons with limited physical capacity outperform persons with no limitations; there is no direct relationship between a person's physical capacity and a person's work capacity." (Pet. Br. 36.) This is a non sequitur. What Petitioner apparently is trying to say is that there is no absolute relationship between

(Continued on following page)

2. SSA's Treating Physician Rule Does Not Place The Burden Of Persuasion On SSA

A claimant for ERISA disability benefits bears "the burden of proving that he is entitled to a benefit under 29 U.S.C. § 1132(a)(1)(B)." (Pet. Br. 39 (*citing Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1040 (11th Cir. 1998); *Fuja v. Benefit Trust Life Ins. Co.*, 18 F.3d 1405, 1408 (7th Cir. 1994)).) Petitioner relies on a supposed difference in the burden of proof between claims for ERISA and Social Security disability benefits as reason not to utilize a treating physician rule in the judicial review of denials of ERISA benefits. (Pet. Br. 23; *see also id.* 15, 45.) Petitioner's argument rests on an erroneous evaluation of the burden of proof in SSA proceedings. According to Petitioner, a treating physician rule *is* compatible with SSA proceedings because in those proceedings the "burden is ultimately on the SSA, and not the claimant, to prove

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the severity of a claimant's medical diagnosis and a claimant's functional limitations. If true, this basic proposition is reason *for* a treating physician rule because a treating physician is best situated to assess how an individual claimant's medical diagnosis actually affects the claimant's ability to function. In contrast, an examining physician or non-examining physician might consider every claimant as an average or typical case. A treating physician is best suited to know whether a medical diagnosis of a specific severity has more or less impact on an individual claimant than in the average case.

But Petitioner does not consistently suggest or argue that there is *no* correlation between the severity of a claimant's medical diagnosis and the claimant's functional limitations. In fact, Petitioner apparently argues for reliance on Dr. Mitri's independent medical examination precisely because Dr. Mitri supposedly could deduce from the severity of Petitioner's medical diagnoses Respondent's functional limitations. (Pet. Br. 33, 44.)

that the claimant is not totally disabled from any substantial gainful activity." (Pet. Br. 23.) Petitioner cites a footnote in *Yuckert*, which refers to the "burden of proof" in SSA proceedings as shifting to SSA at step five. (Pet. Br. 23 (*citing Yuckert*, 482 U.S. at 146 n.5).) But it is settled law that a claimant for Social Security benefits has the burden of persuasion through step four in SSA proceedings, the analogous step of SSA's five-step sequential evaluation to Petitioner's "regular occupation" ERISA disability standard relevant to this case. *See Pinto*, 249 F.3d at 844 ("At step four, claimants have the burden of showing that they can no longer perform their past relevant work."). Because SSA applies its treating physician rule at step four when determining a claimant's residual functional capacity, *see* 20 C.F.R. § 404.1527 (2002); SSR 96-5p,[20] it cannot be true that a treating physician rule shifts the burden of persuasion to the adjudicator or plan administrator. There is no tension between SSA's treating physician rule and an SSA claimant's burden at step four to persuade SSA that he cannot do his past relevant work. Although there has been a treating physician rule in Social Security law for decades, Petitioner does not cite a single case holding that SSA's treating physician rule cannot be applied at step four of the five-step sequential evaluation because at step four the claimant, not SSA, has the burden of persuasion.[21]

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[20] *At* http://www.ssa.gov/OP_Home/rulings/.

[21] The burden of proof includes the burden of production of evidence and the burden of persuasion. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). In *Yuckert*, this Court recognized that SSA has the authority to define through regulation the burden of proof in Social Security disability proceedings. *Yuckert*, 482 U.S. at 146 n.5

(Continued on following page)

H. A Treating Physician Rule Considers Whether A Treating Physician Responds To A Request For More Information

Petitioner sets forth as an objection to a treating physician rule that the Ninth Circuit below did not consider that Respondent did not provide additional information from a treating physician when the plan administrator asked Respondent to submit examining physician Dr. Mitri's report to a treating physician for comment. (Pet. Br. 44.) This is no defect in the treating physician rule. Under that rule, an adjudicator, plan administrator, and court may consider the fact that a claimant did not respond to a request to provide additional information from a treating physician. *See Tidwell v. Apfel*, 161 F.3d 599, 602 (9th Cir. 1998) (approving an ALJ's rejection of a treating physician's opinion because the treating physician gave an inadequate response to a request for additional information); 20 C.F.R.

(*citing Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981)). In footnote five of *Yuckert*, this Court did not distinguish between the burdens of production and persuasion, stating broadly that the Agency "is required to bear this burden [of proof] only if the sequential evaluation process proceeds to the fifth step." *Yuckert*, 482 U.S. at 146 n.5. This Court referred to the shifting burden *of production* of *vocational* evidence from the claimant to the Agency at step five. *Id.*; *see also Heckler v. Campbell*, 461 U.S. 458 (1983) (describing the Agency's burden to provide evidence of jobs at step five); *Tackett v. Apfel*, 180 F.3d 1094, 1098 n.3 (9th Cir. 1999) (describing "elusive" nature of shifting burden of proof in SSA proceedings). This Court in *Yuckert* did not reach the issue of whether a claimant or SSA has the burden *of persuasion* at step five. On this issue, the Circuits are split. *Compare Curry v. Apfel*, 209 F.3d 117, 122-23 (2d Cir. 2000) (placing burden of persuasion on SSA at step five); Acquiescence Ruling 00-4(2), 65 Fed. Reg. 54,879 (2000) (SSA disagreement with *Curry*), *with Her v. Commissioner of Social Security*, 203 F.3d 388, 391 (6th Cir. 1999) (placing burden of persuasion on claimant at step five). There is no need to reach the issue in this case.

§§ 404.1512(e), 404.1527(c)(3) (2002) (regulatory procedure for recontacting a treating physician).

IV. A Treating Physician Rule Is Compatible With Deferential Judicial Review

A. Petitioner Seeks Review Significantly More Deferential Than Even Substantial Evidence Review

Petitioner erroneously asserts that application of a treating physician rule is incompatible with deferential judicial review such as abuse of discretion review or substantial evidence review. (Pet. Br. 24-25.) For example, Petitioner protests that the Ninth Circuit's treating physician rule is inconsistent with deferential substantial evidence review because the Ninth Circuit requires either clear and convincing reasons or specific and legitimate reasons to justify rejection of a treating physician's opinion. (Pet. Br. 24.) Neither the Ninth Circuit nor any other Circuit has understood the application of a treating physician rule to require more than substantial evidence in order to justify affirmance of an administrative denial of Social Security benefits. Nor could it, given the Social Security Act. *See* 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive"). And the Ninth Circuit's treating physician rule does not require more than substantial evidence to support a denial of benefits: it requires exactly "substantial evidence" to support a denial of benefits. *See, e.g.*, *Smolen*, 80 F.3d at 1286. The Ninth Circuit correctly does not understand its treating physician rule in the Social Security context as overriding the statutorily prescribed substantial evidence standard of review. 42 U.S.C. § 405(g).

In support of its argument that the Ninth Circuit's treating physician rule is incompatible with substantial evidence review, Petitioner seems to rely on Richard J. Pierce's *Administrative Law Treatise* (2002), in which Pierce supposedly criticizes the Second Circuit's treating physician rule. (Pet. Br. 28 n.12, 41 (*citing Administrative Law Treatise*, §§ 9.10, 11.3).) Pierce objects in part to the Second Circuit's rule described in *Stieberger v. Bowen*, 801 F.2d 29, 31 (2d Cir. 1986). *See Administrative Law Treatise* §§ 9.10, 11.3. This is no longer the Second Circuit's rule. In *Schisler III*, the Second Circuit held that its prior treating physician caselaw was superseded by SSA's regulations promulgated in 1991. 3 F.3d at 569. The Second Circuit now has a mature, flexible treating physician rule that aids judicial review under the substantial evidence standard. *Id.* (*following* 20 C.F.R. § 404.1527 (2002)).

Deferential judicial review such as substantial evidence review is based on the "whole" evidentiary record. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 481-89 (1951). Petitioner attacks the treating physician rule as inconsistent with deferential review of the "entire medical record." (Pet. Br. 24.) On the contrary, a treating physician rule neither prevents nor discourages reasoned consideration of the whole record. The treating physician rule itself emphasizes consideration of the whole record. *See* 20 C.F.R. § 404.1527(d)(4) (2002) ("Generally, the more consistent an opinion is *with the record as a whole*, the more weight we will give to that opinion.") (emphasis added). In order to assess whether an adjudicator or plan administrator properly accepted *or* rejected a treating physician's opinion, it is necessary to review the treating physician's opinion in the context of the other record evidence, including the treating physician's clinical findings, other medical opinions and findings, and non-medical

facts. *See Magallanes*, 881 F.2d at 751-55 (affirming denial of benefits after review of the "whole" record, including multiple medical opinions and findings from various physicians).[22]

Instead of inhibiting consideration of the whole record on deferential judicial review, a treating physician rule focuses the court's attention on important evidence: treating physician opinions. In almost all cases involving a determination of disability based on a medical condition, a claimant's treating physician's opinion deserves thoughtful consideration even if the court's ultimate conclusion is to ratify the adjudicator's or plan administrator's rejection or endorsement of the treating physician's opinion. The mature, flexible treating physician rule as set forth in Ninth Circuit caselaw and SSA regulations aids a court's review of the whole record because it identifies for the court important evidence. This rule neither requires nor implies that evidence other than a treating physician's opinion must or should be ignored.

In any case, Petitioner does not welcome deferential review based on the whole record. Petitioner is hostile to deferential review based on the whole record. As the Ninth Circuit described in its decision below, Petitioner maintains that a plan administrator need not consider *any* evidence contrary to the plan administrator's chosen result:

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[22] *See also Clifford*, 227 F.3d at 871 (medical opinions are evaluated with "*all* relevant evidence") (emphasis in original); *Prosch v. Apfel*, 201 F.3d 1010, 1013 (8th Cir. 2000) (a treating physician's opinion is evaluated "in light of the record as a whole").

> Because the issue of an apparent conflict of interest was litigated below, Black & Decker received ample opportunity to demonstrate that its termination of Nord's benefits was free from conflict by advancing sound reasons for its denial of benefits. It has provided none. *Rather, it has simply asserted at every turn, and again before this Court, that it was under no duty to consider evidence that was unfavorable to its determination, whether coming from Nord's physicians or from its own human resources representative. . . .*

(Petition App. 14 (emphasis added).) This position is unreasonable and a breach of a plan administrator's fiduciary duty to provide "full and fair" review. 29 U.S.C. § 1133(2). Moreover, it is inconsistent with this Court's jurisprudence of deferential judicial review emphasizing consideration of the "whole" record, including evidence that "detracts" from the disputed finding. *Universal Camera Corp.*, 340 U.S. at 488.

B. A Court Can Apply A Treating Physician Rule And Respect A Factfinder's Responsibility To Resolve Evidentiary Conflicts

Petitioner contends that the Ninth Circuit's treating physician rule impedes or prevents a plan administrator from weighing conflicting evidence. (Pet. Br. 47.) This is not an argument against the Ninth Circuit's treating physician rule. The Ninth Circuit's treating physician rule neither impedes nor prevents the weighing of conflicting evidence, but rather requires the reasonable resolution of evidentiary conflicts. *See Thomas v. Barnhart*, 278 F.3d 947, 956-57 (9th Cir. 2002) (affirming finding of non-disability based on the reasonable resolution of conflicting medical opinions); *Tonapetyan v. Halter*, 242 F.3d 1144, 1149 (9th Cir. 2001) (holding that ALJ properly resolved a conflict among medical opinions when rejecting a claimant's allegations); *Magallanes*, 881 F.2d at 751-55 (affirming finding of non-disability based on the reasonable resolution of conflicting medical opinions); *Allen v. Heckler*, 749 F.2d 577, 579 (9th Cir. 1984) (same).[23]

Petitioner's argument if correct would be astonishing. There are more than 15,000 civil actions annually challenging SSA's administrative decisions denying claims of disability.[24] *See* 42 U.S.C. § 405(g). If Petitioner were correct, the lower courts could not both enforce SSA's treating physician rule, *see* 20 C.F.R. § 404.1527 (2002), *and* respect a factfinder's responsibility to weigh conflicting evidence, *see Perales*, 402 U.S. at 399 ("We therefore are presented with the not uncommon situation of conflicting medical evidence. The trier of fact has the duty to resolve that conflict."). But the lower courts discharge both duties every day.

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[23] *See also Mastro*, 270 F.3d at 179 (affirming ALJ's rejection of treating physician's opinion given conflicting evidence); *Stanley v. Secretary of Health and Human Servs.*, 39 F.3d 115, 118 (6th Cir. 1994) (ALJ reasonably resolved conflict among a treating physician's opinions); *Williams v. Shalala*, 997 F.2d 1494, 1499 (D.C. Cir. 1993) (affirming rejection of treating physician's opinion given "contradictory" evidence).

[24] Office of Human Resources and Statistics, Admin. Office of the U.S. Courts, *Federal Judicial Caseload Statistics* (Mar. 2002), Table C3, *at* http://www.uscourts.gov/caseload2002/contents.html. About 700 district-court dispositions under 42 U.S.C. § 405(g) annually are appealed to the Courts of Appeals. *Id.* at Table B7.

CONCLUSION

The judgment of the Court of Appeals for the Ninth Circuit should be affirmed.

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APPENDIX

20 C.F.R. § 404.1527 (2002), provides in full:

(a) *General.*

(1) You can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. See § 404.1505. Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. See § 404.1508.

(2) Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(b) *How we consider medical opinions.* In deciding whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive.

(c) *Making disability determinations.* After we review all of the evidence relevant to your claim, including medical opinions, we make findings about what the evidence shows.

(1) If all of the evidence we receive, including all medical opinion(s), is consistent, and there is sufficient evidence for us to decide whether you are disabled, we will make our determination or decision based on that evidence.

(2) If any of the evidence in your case record, including any medical opinion(s), is inconsistent with other evidence or is internally inconsistent, we will weigh all of the evidence and see whether we can decide whether you are disabled based on the evidence we have.

(3) If the evidence is consistent but we do not have sufficient evidence to decide whether you are disabled, or if after weighing the evidence we decide we cannot reach a conclusion about whether you are disabled, we will try to obtain additional evidence under the provisions of §§ 404.1512 and 404.1519 through 404.1519h. We will request additional existing records, recontact your treating sources or any other examining sources, ask you to undergo a consultative examination at our expense, or ask you or others for more information. We will consider any additional evidence we receive together with the evidence we already have.

(4) When there are inconsistencies in the evidence that cannot be resolved, or when despite efforts to obtain additional evidence the evidence is not complete, we will make a determination or decision based on the evidence we have.

(d) *How we weigh medical opinions.* Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider

all of the following factors in deciding the weight we give to any medical opinion.

(1) *Examining relationship.* Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) *Treatment relationship.* Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) *Length of the treatment relationship and the frequency of examination.* Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have

obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) *Nature and extent of the treatment relationship.* Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) *Supportability.* The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) *Consistency.* Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) *Specialization.* We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) *Other factors.* When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(e) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) *Opinions that you are disabled.* We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that

you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (e)(1) and (e)(2) of this section.

(f) *Opinions of nonexamining sources.* We consider all evidence from nonexamining sources to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (e) of this section. In addition, the following rules apply to State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult in connection with administrative law judge hearings and Appeals Council review:

(1) At the initial and reconsideration steps in the administrative review process, except in disability hearings, State agency medical and psychological consultants are members of the teams that make the determinations of disability. A State agency medical or psychological consultant

will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or equals the requirements for any impairment listed in Appendix 1 to this subpart, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case record but are not themselves evidence at these steps.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. They will consider opinions of State agency medical or psychological consultants, other program physicians and psychologists, and medical experts as follows:

(i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. However, State agency medical and psychological consultants and other program physicians and psychologists are highly qualified physicians and psychologists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings of State agency medical and psychological consultants or other program physicians or psychologists as opinion evidence, except for the ultimate determination about whether you are disabled. See § 404.1512(b)(6).

(ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician or psychologist, the administrative law judge will evaluate the findings using

relevant factors in paragraphs (a) through (e) of this section, such as the physician's or psychologist's medical specialty and expertise in our rules, the supporting evidence in the case record, supporting explanations provided by the physician or psychologist, and any other factors relevant to the weighing of the opinions. Unless the treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency medical or psychological consultant or other program physician or psychologist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from medical experts on the nature and severity of your impairment(s) and on whether your impairment(s) equals the requirements of any impairment listed in appendix 1 to this subpart. When administrative law judges consider these opinions, they will evaluate them using the rules in paragraphs (a) through (e) of this section.

(3) When the Appeals Council makes a decision, it will follow the same rules for considering opinion evidence as administrative law judges follow.

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In the Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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INTEREST OF *AMICUS CURIAE*[1]

The National Employment Lawyers Association (NELA) and its 67 state and local affiliates have a membership of over 3,000 attorneys, and NELA is the country's only professional membership organization of lawyers who regularly represent employees in labor, employment and civil rights disputes. NELA supports precedent-setting litigation affecting the rights of individuals in the workplace. NELA has filed *amicus curiae* briefs before this Court and numerous courts of appeals regarding the proper interpretation and application of the Employee Retirement Income Security Act (ERISA) to ensure that the rights of workers are fully protected. For example, NELA participated in filing *amicus curiae* briefs in this Court's decisions in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); and *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999).

ERISA was enacted to protect the rights of employees and beneficiaries who participate in private, employer-sponsored employee benefit plans. In NELA's view, the treating physician rule, which is at issue in this case, protects employees who become disabled and need access to the disability benefits that they have earned through their employment. Those who review disability claims must exercise their discretion in a manner consistent with both the protections of the statute and their fiduciary duties under the benefit plan.

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[1] Pursuant to Supreme Court Rule 37.6, *amicus* states that no person or entity other than the *amicus curiae*, and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. Written consent to the filing of this brief has been obtained from the parties in accordance with Supreme Court Rule 37.3(a). Copies of the consent letters have been filed with the Clerk.

For these reasons, *amicus* respectfully requests that the Court consider its views in support of the Respondent.

SUMMARY OF ARGUMENT

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Court explained, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts §187, cmt. d (1959)). Since that time, "courts have struggled to give effect to this delphic statement, and to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 383 (3d Cir. 2000). Recently the Court pondered the same question in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151, 2169 n.15 (2002) ("It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest.").

After *Firestone*, the circuits have struggled mightily to find a reasonable and workable methodology for determining whether an employee benefit plan fiduciary has abused its discretion in its decision to deny benefits. Although most of the case law has applied Factor Six of Comment d to § 187 of the Restatement (Second) of Trusts, *Nord v. The Black & Decker Disability Plan*, 296 F.3d 823 (9th Cir. 2002), allows this Court to examine both Factor Four and Factor Six, and to give much needed guidance in how courts should apply these factors. Factor Four provides that the existence of an external standard by which the reasonableness of the fiduciary's conduct can be judged is relevant to a determination of whether there has been an abuse of discretion. Factor Six provides that the existence of a conflict of interest is also relevant to this determination. *Nord* concluded that the plan administrator's decision to ignore treating physicians' opinions, as well as inconsistencies in the plan's positions and irregularities in the administrative process, tended to show that the fiduciary allowed its conflict of interest to infect its decision. In applying the "abuse of discretion" standard, the courts first determine if the denial of benefits is "wrong"—just as they would under the *de novo* standard of review. If the plan grants discretion to the fiduciary, the court then must decide how much discretion to give a conflicted fiduciary, or to a fiduciary who ignores an objective external standard. A "wrong" decision by a conflicted fiduciary who ignores an objective external standard without explanation, whose financial interests are directly advanced by a benefits denial, and who has demonstrated a lack of objectivity in the handling of the claim, should not be enforced.

Amicus submits that the time has come for this Court to put meat on the bones of Restatement § 187 cmt. d, to instruct the lower courts as to how the Restatement "factors" are to be taken into account, and to inform the lower courts of what to do when those factors are present.

The determination of what constitutes a conflict of interest, and how the conflict weighs as a "factor," has plagued courts for the last fourteen years, resulting in essentially five different standards among the circuits: a conflicted decision is presumptively void (Eleventh Circuit); a conflicted decision is presumptively void if there is evidence tending to show that the conflict infected the decision (Ninth Circuit); abuse of discretion will still be applied, but with "more bite" (First Circuit); if a plaintiff produces "smoking gun" evidence proving that a conflict infected the decision, then the standard of review is *de novo* (Second Circuit); and various sliding scale approaches (remaining circuits). *Amicus* urges the Court to

provide clear guidance to the lower courts on this issue so as to curb the enormous amount of litigation and utilization of judicial resources that this issue has generated. *Amicus* recommends the Eleventh Circuit's approach as a clear and workable standard: a conflicted administrator's decision will stand only if the administrator can show that there was no self-interest in making a decision that would be "wrong" under *de novo* review. *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1556-68 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).

ARGUMENT

I. INTRODUCTION

In some circuits, plan administrators, particularly insurance companies, have been given *carte blanche* to act as the sole arbiters of claims despite their self-interest in denying those claims. This case presents the Court with the opportunity to redress this untenable situation, and to apply reasonable limitations on the administrators' powers by recognizing the inherent unfairness in allowing one party to a dispute the unfettered discretion to also decide it.

We suggest that the Court do so by clarifying how the factors set forth in Comment d to § 187 of the Restatement (Second) of Trusts should be applied; specifically, by adopting the analysis of either the Eleventh Circuit or the Ninth Circuit. Such an approach strikes a balance between recognition of the trust nature of the relationship between the plan participant and the plan administrator and protection of the participant from the unfairness that may result from giving the administrator virtual *carte blanche*, regardless of its bias.

II. THE RESTATEMENT (SECOND) OF TRUSTS ENUMERATES FACTORS THAT COURTS SHOULD APPLY IN DETERMINING WHETHER THERE IS AN ABUSE OF DISCRETION.

The Restatement (Second) of Trusts § 187, "Control of Discretionary Powers," states: "Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court, except to prevent an abuse by the trustee of his discretion." Comment d provides:

> *Factors in determining whether there is an abuse of discretion.* In determining the question whether the trustee is guilty of an abuse of discretion in exercising or failing to exercise a power, the following circumstances may be relevant: (1) the extent of the discretion conferred upon the trustee by the terms of the trust; (2) the purposes of the trust; (3) the nature of the power; (4) the existence or nonexistence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged; (5) the motives of the trustee in exercising or refraining from exercising the power; (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.

Id.

In actions brought challenging the denial of benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), where the plan document gives the administrator discretion to make eligibility determinations and to construe the terms of the plan, several factors identified in Comment d will remain constant because ERISA controls the purpose of the trust, and plans and insurance policies have now adopted boilerplate language granting discretion. Therefore, the extent of the discretion, the purpose of the

trust, and the nature of the administrator's power will be largely identical in the vast majority of such actions. *See Brown*, 898 F.2d at 1564-65 (noting that the purpose of the trust and the nature of the administrator's power "have a constant quality dictated by ERISA."). By contrast, the remaining factors—the existence of an external standard by which to judge the reasonableness of the administrator's action, the motives of the administrator, and the existence of a conflicting interest—may differ significantly in each action.

Following this Court's decision in *Firestone*, courts for the most part have focused on the question of whether the administrator is guilty of an abuse of discretion due to the existence of a conflict of interest and the corollary question of what evidence is necessary to establish such a conflict. An exploration of the motives of the administrator, where such motives can be discerned, has generally been subsumed into the analysis of the administrator's actual or potential conflict of interest. The existence of an external standard by which the reasonableness of the administrator's conduct can be judged has remained relatively unexplored by the courts, but provides another useful method for determining whether an administrator is guilty of an abuse of discretion.

III. THE TREATING PHYSICIAN RULE PROVIDES AN EXTERNAL STANDARD AGAINST WHICH THE ADMINISTRATOR'S DECISION MAY BE JUDGED UNDER RESTATEMENT § 187 CMT D, FACTOR (4). VIOLATION OF THAT STANDARD, WITHOUT A REASONABLE EXPLANATION, SHOULD RESULT IN A COURT'S UNWILLINGNESS TO ENFORCE A WRONG DECISION.

The treating physician rule, when correctly stated, provides just the sort of objective and external standard

contemplated by the Restatement. However, neither Petitioner nor its *amici* have accurately presented the issue set forth in *Nord* or in its predecessor, *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), *petition for cert. filed*, 71 USLW 3001 (U.S. Jun 13, 2002) (No. 01-1840). Nor has there been an accurate presentation to this Court as to the meaning of and history behind the Social Security Administration's "treating physician rule." *Nord* and *Regula* did not use the treating physician rule as a rule of default; instead, the plan's violation of the rule was presented as a factor to be considered in applying the discretionary standard of review.

As the Restatement (Second) of Trusts notes, one relevant factor for courts to evaluate in determining whether the administrator is guilty of an abuse of discretion is to examine the reasonableness of the administrator's or fiduciary's decision in light of an external standard where such a standard exists. The Restatement (Second) of Trusts § 187, cmt. d. The treating physician's opinion on medical issues (including, e.g., the medical necessity of a treatment and a claimant's limitations) is just such an external standard by which a court can judge the fiduciary's conduct. The treating physician has the most direct clinical information about the claimant, makes determinations in accordance with professional medical standards, and is bound to provide truthful information about the claimant's medical condition and limitations. *See, e.g., Murray v. Heckler*, 722 F.2d 499, 502 (9th Cir. 1983). Accordingly, the treating physician's opinion provides an external measure against which the administrator's decision may be judged for reasonableness.

A. Origin of the Treating Physician Rule

The development of the treating physician rule in Social Security cases resulted from a recognition that "disability"

is a concept that may be statutorily or contractually defined, but requires an individualized assessment to determine whether a particular claimant meets that definition. Neither the Listing of Impairments (20 C.F.R. § 404, Regulations No. 4, Subpart P, Appendix 1), nor the Medical-Vocational Rules (20 C.F.R. § 404, Regulations No. 4, Subpart P, Appendix 2), can completely resolve the question of whether an individual is incapable of engaging in "any substantial gainful activity" for purposes of Social Security Disability Insurance. 42 U.S.C. § 423(d)(1)(A) (Social Security definition of "disability").

The treating physician rule was developed to protect Social Security disability claimants against arbitrary decision-making. Although Administrative Law Judge ("ALJ") decisions are subject to judicial review, 42 U.S.C. § 405(g), that review is deferential; and the ALJ's decision will be upheld so long as it is supported by substantial evidence. In *Richardson v. Perales*, 402 U.S. 389, 401 (1971), this Court defined substantial evidence as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." (citations omitted). Thus, the treating physician rule was adopted as a means "for courts to introduce judicial discretion into their review of the disability determinations made by the [ALJ]." Schneider, *A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. CHI. L. SCH. ROUNDTABLE 391, 391 (1996). However, neither the case law that preceded the promulgation of a specific regulation adopting the treating physician rule, nor the regulation itself (20 C.F.R. §§ 404.1527, 416.927), requires abject deference to the treating doctor's opinion, as Petitioner's "Question Presented" implies. Nor, in either *Nord* or *Regula*, is there an unquestioning acceptance of the treating doctor's opinion as Petitioner and its *amici* claim. Courts are fully capable of recognizing that there are circumstances that may preclude acceptance of the treating doctor's opinion, and they have applied the treating physician rule in a sensible and practical manner.

B. Courts Find the Treating Physician Rule to Be Useful and Reasonable, and It Should Be Incorporated into ERISA Jurisprudence.

Absent deference to the treating physician's opinion, claimants may unfairly suffer the denial or termination of benefit payments under plans and insurance policies containing discretionary language. In many cases, plan participants lack a reasonable opportunity to protect against the denial or loss of benefits so long as an insurer, supposedly acting in a fiduciary capacity, can proffer the opinion of a consulting physician who certifies non-disability even in the absence of an examination. Without the treating physician rule, the treating doctor's opinion can be simply disregarded in favor of a clearly less qualified opinion. Under a deferential standard of review, that benefits denial would stand.

Nord offers a clear example of such a situation. There, the Ninth Circuit found "the administrator appears merely to have preferred to rely upon the more favorable conclusions of its own examiner." *Nord v. The Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002). The treating physician rule guards against such actions. At the same time, as the Ninth Circuit has made clear, the treating physician rule in ERISA cases "is not absolute." *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1140 (9th Cir. 2001), *petition for cert. filed*, 71 USLW 3001 (U.S. Jun 13, 2002) (No. 01-1840). The plan administrator may reject the treating physician's opinions, so long as the administrator provides "specific, legitimate reasons that are based on substantial evidence in the record." *Id.* at 1147.

Now that the treating physician rule has been incorporated into regulations (20 C.F.R. §§ 404.1527; 416.927), the Social Security Administration has clarified the basis of the principle:

> Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations.

20 C.F.R. § 404.1527(d)(2).

Nonetheless, the treating physician's opinion will not control unless it meets carefully defined criteria. For example, the longer the treatment relationship and the more times the treating doctor has examined the patient, the more informed is the "longitudinal picture" of the claimant's impairment. 20 C.F.R. § 404.1527(d)(2)(I). The nature and extent of the treatment relationship is also important. Of the greatest significance, though, is that for the treating physician's opinion to be given controlling weight, it must be supportable; i.e., it must be consistent with "medical signs and laboratory findings" and with the record as a whole. 20 C.F.R. §§ 404.1527(d)(3) and (4). Moreover, more weight is given "to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist." 20 C.F.R. § 404.1527(d)(5).

Hence, although these are regulations promulgated by the Social Security Administration rather than the courts, they were developed as a policy that "takes into account the concerns raised by the . . . courts." 56 Fed. Reg. 36932, 36950 (1991). Since those same policy concerns are equal-

ly applicable to issues arising in disability benefit claims brought under ERISA, these straightforward, commonsense principles are a useful external standard in adjudicating such claims because it cannot be disputed that "the effects of medical conditions on individuals vary so widely, and because no two cases are ever exactly alike." *Id.* at 36934. In other words, the treating physician rule strives for a greater measure of accuracy in resolving a "decision-making procedure [that] includes a certain amount of subjectivity and individualization." Schneider, 3 U. CHI. L. SCH. ROUNDTABLE 391, 402.[2]

Although the Petitioner and its *amici* have expressed concern about the honesty of the treating physician, of greater concern to the court in *Regula* was

> the conflict of interest inherent when benefit plans repeatedly hire particular physicians as experts. Especially in cases such as this one, where the plan administrator is also the funding source, these experts have a clear incentive to make a finding of "not disabled" in order to save their employers money and to preserve their own consulting arrangements.

Regula, 266 F.3d at 1143. Moreover, *Regula* explained that courts that have rejected the application of the treating physician rule have done so in the context of health benefit claims, where the physician may have a financial

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[2] Although not every ERISA long-term disability plan uses the Social Security definition of "disability," the treating physician rule should be applied in ERISA jurisprudence because it recognizes that treating physicians' opinions are among the most helpful tools for determining whether an individual meets the plan's definition of disability, since every definition of disability necessitates an informed opinion of the individual's medical condition.

motive to assure payment, unlike disability benefit cases where the patient, not the physician, receives the payment. *Id.* at 1143. The court's differentiation between health benefits claims and disability claims is borne out by the medical articles cited by Petitioner and its *amici*. For example, in Wynia, et al., *Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 183 JAMA 1858, 1863 (2000), the authors limited their presentation to medical benefits and, even there, found manipulation of reimbursement rules "relatively uncommon." Another article, Freeman, et al., *Lying for Patients: Physician Deception of Third-Party Payers*, 159 ARCHIVES OF INT. MED. 2263 (1999), also was restricted to health insurance reimbursement. Neither of these studies provides any support for an argument that a treating physician in a disability case would furnish an opinion that was not warranted by the evidence. Furthermore, the recognized caveats to the application of the treating physician rule operate as a check against such a practice; i.e., if the physician's opinion is inconsistent with the record as a whole, or if that opinion can be disputed by reliance on other clinically supported evidence, then the plan fiduciary does not have to accept it as conclusive.

Thus, the treating physician rule constitutes an application of the *Firestone* instruction to weigh the Restatement factors in determining whether there has been an abuse of discretion. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The treating physician rule both provides an external standard for comparing the reasonableness of the administrator's decision, and illuminates whether an administrator has acted in its own self-interest. Both of these are factors in determining whether the administrator has abused its discretion under § 187 of the Restatement (Second) of Trusts.

IV. COURTS NEED GUIDANCE AS TO WHAT CONSTITUTES AN ABUSE OF DISCRETION UNDER THE FACTORS STATED IN *FIRESTONE* AND IN THE RESTATEMENT (SECOND) OF TRUSTS.

Since this Court's decision in *Firestone*, the lower courts have been reviewing decisions of administrators granted with discretionary authority under the abuse of discretion standard. Where the administrator had an actual or potential conflict of interest, the courts have sought to apply a less deferential or more searching standard of review. However, as discussed in detail below, in the fourteen years since *Firestone*, the circuits have been unable to agree upon a workable paradigm for their analysis of what constitutes a potential or actual conflict of interest, and for their analysis of how potential or actual conflicts of interest should be "weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Firestone*, 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187). Indeed, courts have even parted company in analyzing whether the distance between abuse of discretion review and *de novo* review can be traversed along a sliding scale or whether a significant violation of one of the Comment d factors means that a court will reverse a wrongful denial. *Compare, e.g., Lang v. Long Term Disability Plan of Sponsor Applied Remote Technology, Inc.*, 125 F.3d 794, 798 (9th Cir. 1997) (if the administrator's decision was tainted by a conflict of interest, then it is entitled to no deference), *with Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3d Cir. 2000) (adopting a sliding scale analysis which heightens the degree of scrutiny in proportion to the administrator's conflict of interest). *See also Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151, 2169 n.15 (2002) ("It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest.").

The Court should take this opportunity to clarify how lower courts should determine whether an actual or potential conflict of interest exists, and once such a conflict is found, how it is to be weighed on abuse of discretion review. Such guidance will lead to a more uniform treatment of claims challenging benefit denials under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

V. THE COURTS ARE IN A STATE OF CONFUSION WHEN DETERMINING HOW A CONFLICT AFFECTS THE STANDARD OF REVIEW.

In the aftermath of *Firestone*, the lower courts have adopted essentially five different approaches to determining how the existence of a conflict "weighs" in the review of a discretionary decision. *See* ABA SECTION OF LABOR AND EMPLOYMENT LAW, EMPLOYEE BENEFITS LAW, 2nd ed., 442-48 (2002). The Eleventh Circuit mandates that a conflicted decision is presumptively void. *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1566-68 (11th Cir. 1990). The Ninth Circuit has established that a conflicted decision is presumptively void if there is evidence tending to show that the conflict infected the decision. *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995); *Lang*, 125 F.3d at 798. The First Circuit finds that abuse of discretion will still be applied, but with "more bite." *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999). The Second Circuit employs a standard whereby the plaintiff bears the burden of finding a "smoking gun" necessary to show that a conflict of interest caused the benefit to be denied. *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996). The remaining circuits subscribe to some version of a "sliding scale" approach, as described below. The only conclusion that can be drawn from the courts' disarray in the aftermath of *Firestone* is that they need further guidance.

Of these standards, only those of the Eleventh and Ninth Circuits ensure consistent adjudication, with the Eleventh Circuit's standard being the more practical of the two. *Amicus* urges the Court to adopt the standard of either the Ninth or Eleventh Circuit for the reasons set forth in detail below. The approaches of the remaining circuits have resulted in inconsistent results in determining both what triggers the slide down the scale and how far down a court should slide.

A. The Sliding Scale Approach Is Subjective and Has Resulted in Inconsistent Adjudication among the Circuits.

The sliding scale approach is unworkable. Although most circuits claim to use this approach, none are able to use it consistently, as it is an inherently subjective standard. The sliding scale itself, with all of its various gradations and calibrations, is simply impractical, as illustrated by the circuits' differing articulations of it. Indeed, at least two of the circuits that have adopted the sliding scale have explicitly expressed reservations as to its use.

Third Circuit: The Third Circuit explained that in its application of the sliding scale approach, the court "approximately calibrat[es] the intensity of our review to the intensity of the conflict." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3d Cir. 2000). However, at the same time the court also acknowledged that the standard is "intellectually unsatisfying, or at least discomforting . . . [for] it is not clear how the process required by the typical arbitrary and capricious review changes." *Id.* at 392. Indeed, as the case law reveals, the sliding scale approach is as subjective and impractical as it is vague and imprecise.

Fourth Circuit: The Fourth Circuit in *Elliot v. Sara Lee Corp.*, 190 F.3d 601, 605 (4th Cir. 1999), modified the

abuse of discretion standard to the extent necessary to counteract any "influence unduly resulting from the conflict." In *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 233-34 (4th Cir. 1997), the court explained that "[t]he more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan terms, the more objectively reasonable the administrator or fiduciary's decision must be and the more substantial the evidence must be to support it." This explanation, however, only underscores the inevitable subjectivity that results in inconsistent adjudication under the sliding scale approach: the word "more" does not quantify how far down the scale a court should slide. This is an unmanageable test in the guise of guidance to the lower courts.

Fifth Circuit: The Fifth Circuit in *Vega v. National Life Ins. Servs.*, 188 F.3d 287, 297 (5th Cir. 1999) reaffirmed that "[t]he greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be." Again, the words "greater" and "less" defy the possibility of consistent adjudication because they are so vague.

Sixth Circuit: The Sixth Circuit acknowledges that a conflict of interest should be taken into account as a factor in determining whether the decision was arbitrary and capricious, and examines whether the administrator was motivated by self-interest in rendering its decision. *Peruzzi v. Summa Medical Plan*, 137 F.3d 431, 433 (6th Cir. 1998). However, as typical of circuits employing the sliding scale approach, the Sixth Circuit does not articulate a standard for how or to what degree this factor must be taken into account. This kind of vagueness is disturbing and unworkable, as acknowledged by the Seventh Circuit.

Seventh Circuit: In an attempt to apply *Firestone's* instruction to weigh self-interest as a factor in the standard of review, the Seventh Circuit noted the need for additional judicial guidance on this issue: "How *much* does it weigh? [One court] recently concluded that it can't weigh very much without exceeding the judicial capacity to tailor standards of review. Judges understand deferential and non-deferential review, but intermediate variations blur into one another without promoting understanding or consistent adjudication." *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 986 (7th Cir. 1999). The Seventh Circuit got the issue exactly right: terms such as "more" or "greater" or "less" that litter sliding scale adjudication do not answer the question of "how much." However, perhaps for lack of additional guidance, the Seventh Circuit also employs the sliding scale approach, despite questioning its ability to promote "understanding or consistent adjudication." *Id.*; *see also Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 815 (7th Cir. 1997) ("The more serious the conflict, the less deferential our review becomes.")

Eighth Circuit: The Eighth Circuit determined in *Clapp v. Citibank N.A. Disability Plan*, 262 F.3d 820, 827 (8th Cir. 2001) that a court should give less deferential sliding scale review if the claimant produces material probative evidence that a palpable conflict was connected to the administrator's decision so as to cause a serious breach of fiduciary obligation. However, like other circuits, the Eighth Circuit acknowledges that there is an inherent problem with this approach: if the plan participant has produced the required evidence to trigger a sliding scale review, the plan participant also likely would be able to receive a favorable result under the traditional abuse of discretion review. *Barnhart v. UNUM Life Ins. Co.*, 179 F.3d 583, 589 n.9 (8th Cir. 1999) (The standard "presents a considerable hurdle for plaintiffs. Logically, a plaintiff who can show that a conflict of interest or serious procedural irregularity caused a serious breach of

the administrator's fiduciary duty will more than likely have substantial evidence showing that the fiduciary's decision was arbitrary and capricious."). Thus, the Eighth Circuit has acknowledged that its own sliding scale approach is essentially meaningless.

These complex and imprecise standards have created confusion in the circuits, and their misapplication at the district court level generate further appellate review and therefore waste judicial resources. *See, e.g., id.* at 588 (holding the lower court failed to analyze conflict issue under standard of the circuit).

Tenth Circuit: In *Pitman v. Blue Cross*, 217 F.3d 1291, 1295 (10th Cir. 2000), the Tenth Circuit held that the court's deference should decrease in proportion to the severity of the conflict. *Accord McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1258-59 (10th Cir. 1998). In *Charter Canyon Treatment Center v. Pool Co.*, 153 F.3d 1132, 1136 (10th Cir. 1998), the Circuit used the vaguest language of all: that the review should be "tempered by" the defendant's possible conflict of interest. Again, however, the Seventh Circuit's apt question of "how much" it should decrease or be "tempered by" remains unanswered under this unworkable standard.

B. The Sliding Scale Approach Generates Inconsistent Approaches Even as to Whether a Financial Conflict of Interest Initiates a Slide Down the Scale.

A particular area of inconsistency that exists among the circuits using the sliding scale standard is the application of the conflict of interest analysis to insurance companies that both fund and administer ERISA plans. Despite the undeniable trust background of ERISA recognized by this Court in *Firestone*, the reality of long-term disability plans today is that they consist overwhelmingly of insurance policies. Even a cursory glance at the plethora of reported cases demonstrates that in the vast majority of cases insurers, who have obvious financial interests at stake, decide the claims.[3] The circuits have attempted to address this reality.

Some circuits hold that when a plan administrator serves in this dual capacity, there is an actual, readily apparent conflict of interest. *See, e.g., Killian v. Healthsource Provident Admin., Inc.*, 152 F.3d 514, 521 (6th Cir. 1998); *Pinto*, 214 F.3d at 384; *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996). These courts note that "insurance companies have an active incentive to deny close claims in order to keep costs down and keep themselves competitive . . . ." *Pinto*, 214 F.3d at 388.

The Seventh Circuit, however, holds that where a fiduciary acts in such a capacity, only a potential conflict exists and the insurer is presumed to be neutral. *Mers v. Marriott Int'l Group Acc. Death and Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), *cert. denied*, 525 U.S. 947 (1998). In *Mers*, the Seventh Circuit found that no conflict existed essentially because the insurer was a "Fortune 500" company and the impact of granting the particular benefit sought in the instant case was minuscule. *Id.* at 1020-21. Following the Seventh Circuit's analysis to its logical conclusion means an insurer, which likely has billions of dollars in assets, would never be deemed to have a financial incentive to deny a claim, because no

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[3] Under the abuse of discretion standard, absent proper application of the Restatement factors, these insurers essentially "serve as judge and jury" for claims against themselves. Conferring such power on a potentially self-interested private party is unprecedented in American jurisprudence. It is also in direct contradiction to the considered determinations of the courts and legislatures of virtually every state that insurance company claim practices must be regulated carefully so as to protect insureds.

single disability claim could possibly be more than minuscule. Of course, this ignores the reality that the cumulation of claims (and potential claim denials) obviously affects any insurer's "bottom line." The Seventh Circuit's superficial analysis in *Mers* demonstrates that the often present "judicial hesitation" to question a fiduciary's motives, even when the fiduciary is an insurance company, can leave beneficiaries unprotected. *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1566-68 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) (espousing a burden-shifting analysis to place the onus on the fiduciary to show lack of improper influence over decision when such conflict exists).

C. The First Circuit's "More Bite" Approach Is Another Version of the Subjective Sliding Scale Approach, and Is Equally Unworkable.

The First Circuit has avoided using "sliding scale" terminology; instead, it characterizes the lesser deference afforded to plan decisions influenced by a conflict of interest as being arbitrary and capricious review with "more bite." *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (holding that "fine gradations in phrasing are as likely to complicate as to refine the standard," and that the "essential requirement of reasonableness has substantial bite itself"). However, the "more bite" approach is just as vague as the sliding scale approach, and cannot ensure consistent adjudication. "Bite" is, at best, just another subjective term, like "sliding scale," and at worst, an approach rendered meaningless by its lack of definition. Thus, in criticizing the "more bite" approach, the Seventh Circuit aptly noted that courts using this standard of review "have never come up with an operational definition of 'more bite' or a specification of the appropriate circumstances for mastication." *Perlman*, 195 F.3d at 981.

The vagueness of the "more bite" standard is illustrated in *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181 (1st Cir. 1998). There, a divided appellate panel seemingly applied the "more bite" analysis to the same record reviewed by the district court and reversed the district court's decision, with little explanation or guidance. If, as the circuit courts recognize, the sliding scale approach lacks clarity and workability, the district courts will certainly have difficulty applying the "more bite" standard, as evidenced by *Doyle*. Thus, litigants and the lower courts lack guidance as to how cases should be presented and decided in the presence of a conflict of interest.

D. The Second Circuit's Approach Also Is Unworkable.

In the Second Circuit, the plan participant must produce "smoking gun" evidence that proves that the administrator's decision was infected by the conflict of interest in order to receive anything but traditional, non-sliding abuse of discretion review. *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996) (holding that plaintiffs have the burden of proving that the conflict of interest affected the administrator's decision). This standard is in direct conflict to *Firestone's* instruction that a conflict of interest must be weighed as a "'facto[r] in determining whether there is an abuse of discretion.'" *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (quoting Restatement (Second) of Trusts § 187). In addition, because this standard requires the plaintiffs to *prove* that an administrator acted on a conflict, it requires them to conduct extensive discovery in order to locate a "smoking gun" showing the conflict, and then go even further to show that the conflict in fact influenced the decision at hand.

Beneficiaries have little chance of finding a "smoking gun" to prove that the administrator acted on a conflict. *See, e.g., Pinto*, 214 F.3d at 379. ("Our rule is also informed by the understanding that 'smoking gun' direct evidence of purposeful bias is rare in these cases so that, without more searching review, benefits decisions will be virtually immunized."). Consequently, it should not be the burden of the beneficiary "'to show that the fiduciary succumbed to this temptation, that he acted in bad faith, that he gained an advantage, fair or unfair, that the beneficiary is harmed.'" *Brown*, 898 F.2d at 1565, quoting *Fulton Nat'l Bank v. Tate*, 363 F.2d 562, 571-72 (5th Cir. 1966).

VI. IT IS TIME FOR THIS COURT TO SET FORTH A CLEAR AND WORKABLE STANDARD FOR DETERMINING WHETHER THERE HAS BEEN AN ABUSE OF DISCRETION

As explained above, the circuits are in disarray about what constitutes a conflict of interest, how it is to be demonstrated, and how to weigh evidence of it. Clearly, the lower courts are in need of a uniform, rational, and practical approach. Both the Eleventh and the Ninth Circuits have established approaches that provide clear standards for assessing whether a conflict of interest is present, and for determining the standard of review in light of that conflict. Both circuits employ a burden-shifting approach when there is evidence of a conflict of interest. *Brown*, 898 F.2d at 1566-68; *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995). As discussed below, the Eleventh Circuit approach provides the clearer standard.

A. The Eleventh Circuit Has Established a Workable Standard Which Will Result in Consistent Adjudication.

In *Brown*, the Eleventh Circuit established a burden-shifting analysis. When the plan participant shows that the administrator was acting under a potential conflict of interest, the burden shifts to the administrator to prove that its decision was not tainted by that conflict. 898 F.2d at 1566-68. Under the Eleventh Circuit's approach, a court first determines whether, looked at from a *de novo* perspective, the administrator's decision is "wrong." *Id.* at 1567 n.12 If the decision would not be wrong under a *de novo* review, then the administrator's decision stands. If the decision would be wrong under a *de novo* review, then the court examines the conflict of interest. Upon this examination, if the administrator was acting under a substantial conflict of interest, then the burden shifts to the administrator to prove its decision was not tainted by self-interest. *Id.* at 1566-67. A financial conflict, such as that which exists when the same party both funds the plan and decides claims, constitutes a substantial conflict of interest. *Id.* at 1561-62, 1568. Indeed, the Eleventh Circuit has stated that an insurance company's

> fiduciary role lies in perpetual conflict with its profit-making rule as a business. . . . Decisions made by the issuing company on behalf of a plan based on a contract of insurance . . . inherently implicate the hobglobin of self-interest. Adverse benefits determinations save considerable sums that are returned to the fiduciary's corporate coffers.

Id. A plan administrator may meet its burden of proving that it did not act in a self-interested manner by, for example, showing that its decision is intended to maxi-

mize benefits to all plan participants in a fiscally responsible way. *Id.* at 1568.[4]

B. The Ninth Circuit Also Employs a Clear Standard

Like the Eleventh Circuit, the Ninth Circuit considers the fact that the administrator both funds and administers the plan to be an "inherent" conflict of interest. *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 797 (9th Cir. 1997). However, for this conflict to affect the standard of review, the beneficiary must come forward with "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show" that the administrator acted on the conflict. *Atwood*, 45 F.3d at 1323.

The Ninth Circuit has found the following evidence to be "material" and "tending to show" that the administrator acted on the conflict: inconsistencies in the plan administrator's reasons for denying the claim, *Lang*, 125 F.3d at 799; insufficiency of a plan administrator's reasons for denying the claim, *Tremain v. Bell Industries, Inc.*, 196 F.3d 970, 977 (9th Cir. 1999); procedural irregularities in the processing of claims, *Freidrich v. Intel Corp.*, 181 F.3d 1105, 1110 (9th Cir. 1999); and, the current subject of the Court's review, rejection of the treating physicians' opinions, *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1147 (9th Cir. 2001), *petition for cert. filed*, 71 USLW 3001 (U.S. Jun 13, 2002) (No. 01-1840).

If the beneficiary produces the required evidence, then the burden shifts to the administrator to show that its determination was not affected by a conflict of interest. *Atwood*, 45 F.3d at 1316. Like the Eleventh Circuit, the

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[4] This is particularly relevant in the case of plans with a fixed corpus, as opposed to insurance companies, for example.

Ninth Circuit proposes that a plan might meet this burden by, for example, "showing how its decision in fact benefitted the plan as a whole . . . [or] that its decision was intended to prevent an unanticipated expenditure that would have depleted the resources available to other beneficiaries of the plan." *Lang*, 125 F.3d at 798. If the administrator cannot meet its burden of showing that its decision was not tainted by self-interest, then the court reviews the determination *de novo*, "without deference to the administrator's tainted exercise of discretion." *Atwood*, 45 F.3d at 1323.

C. Adopting One of These Approaches Will Result in Conserved Judicial Resources and Will Help Fulfill ERISA's Intent.

Adopting either the Eleventh or the Ninth Circuit approach would eliminate substantial conflict within the circuits, and would ensure that a cohesive approach would be uniformly applied throughout the circuits. Moreover, the burden shifting approach of these Circuits makes sense both as a practical matter and as a matter of fulfilling ERISA's intent to protect participants' benefits. As the Eleventh Circuit aptly stated, "[t]he judicial hesitation to inquire into the fiduciary's motives will leave the beneficiaries unprotected unless the existence of a substantial conflicting interest shifts the burden to the fiduciary to demonstrate that its decision is not infected with self-interest." *Brown*, 898 F.2d at 1565-66.

In addition to protecting beneficiaries, the burden-shifting approach is both reasonable and practical because it does not require plaintiffs to somehow locate a "smoking gun" to prove that the conflict infected the administrator's decision, which, as discussed above, is "rare in these cases." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 379 (3d Cir. 2000).

Although both the Ninth and the Eleventh Circuits employ a burden-shifting approach, the difference between their approaches is when the burden shifts. In the Ninth Circuit, although the plan participant does not have to discover a "smoking gun" that definitively shows that the administrator acted on a conflict, the participant must put forth evidence "tending to show" that the administrator acted in its own interest (in addition to showing the "inherent" financial conflict of interest). *Atwood*, 45 F.3d at 1323; *Lang*, 125 F.3d at 797. Once the beneficiary has proffered this evidence, the burden shifts to the administrator to rebut it. *Atwood*, 45 F.3d at 1323. In the Eleventh Circuit, however, the burden shifts when there is a financial or other conflict of interest present. *Brown*, 898 F.2d at 1561-62, 1568. It is then the responsibility of the administrator to show that it did not act on this conflict. *Id.* at 1566-67. The Eleventh Circuit's approach is a clearer standard because it eliminates inevitable inconsistencies in what constitutes evidence "tending to show" a conflict and avoids the need for plaintiffs to conduct discovery to obtain substantial evidence of the conflict outside of the administrative record.[5] Thus, although both approaches are better than the current state of the other circuits, where there are virtually no concrete standards to ensure consistent adjudication, the Eleventh Circuit provides the better approach.

Moreover, both approaches avoid the amorphous and inherently subjective determinations inherent in the sliding scale and "more bite" approaches. Under either the Eleventh Circuit or the Ninth Circuit approach, there is no need to determine the degree of the fiduciary's conflict,

[5] Moreover, it is not logical to assume that in every case in which a financial motive affects an administrator's substantive decision, there also will be some procedural irregularity or other manifest misconduct that is known to the participant and therefore available to demonstrate that the conflict affected the decision.

nor is there any need to determine how far the court should slide away from deference to the administrator's decision or how much more "bite" it should put into its deferential review. In short, where a decision would be wrong under a *de novo* standard and the insurer or other plan fiduciary is unable to demonstrate that the conflict did not affect its decision, then the decision constitutes an abuse of discretion.

Furthermore, these approaches ensure the enforcement of ERISA's duty of loyalty, since administrators will be aware that if they act disloyally, courts will review their decisions *de novo*. As the Solicitor General noted in his *Amicus Curiae* brief in the present matter, "[t]o be sure, once an employer establishes a plan covered by ERISA, plan administrators are fiduciaries, 29 U.S.C. 1002(21)(A), and must administer the plan consistent with their duties of prudence and loyalty." Brief for the United States as *Amicus Curiae* Supporting Petitioner at 12. The approaches of the Eleventh and Ninth Circuits help ensure that administrators adhere to their obligations of loyalty, since if there is evidence that they did not act with loyalty to the beneficiaries, and the administrator cannot rebut this evidence, then a court will review the administrators' decisions *de novo*. Administrators therefore will not be able to hide behind the shield of "discretion" when they have failed to act with the loyalty required of them.

It is true that most employers try (and succeed) in being fair to their employees. However, insurance companies, who handle the bulk of non-pension benefit claims, have more palpable conflicts that may give rise to a greater temptation to disregard ERISA's duty of loyalty. *See, e.g.*, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151, 2169 n.15 (2002) (noting in dictum that there is a "potential for conflict when an HMO makes decisions about appropriate treatment," and that under *Firestone*, "review for abuse of discretion would home in on any

conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised,") (citations omitted). As the Eleventh Circuit noted in *Brown*, a fundamental difference between plans administered by insurance companies and plans "that are truly trusts" is that trustees act for the future well-being of the trust, but this cannot be presumed for insurance companies, since "[a]dverse benefits determinations save considerable sums that are returned to the fiduciary's corporate coffers." 898 F.2d at 1567-68. It is for this reason that courts must have an effective tool for admonishing administrators who have disregarded their duty of loyalty: namely, a *de novo* standard of review when a financial conflict of interest is present.

CONCLUSION

For the reasons stated above, this Court should uphold the ruling below, and use this case as an opportunity to give the lower courts the tools to render consistent adjudication for which they have been searching for fourteen years.

Respectfully submitted,

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Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ of Certiorari To The United States Court of Appeals for the Ninth Circuit

BRIEF *AMICUS CURIAE* OF AARP IN SUPPORT OF RESPONDENT

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BRIEF *AMICUS CURIAE* OF AARP IN SUPPORT OF RESPONDENT

INTEREST OF *AMICUS CURIAE*[1]

AARP is a nonprofit membership organization of approximately 35 million persons age 50 or older, working or retired, that is dedicated to addressing the needs and interests of older Americans. More than 45% of AARP's members are working. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all citizens.[2] In its

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[1] No counsel for any party authored any portion of this brief. No persons other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

[2] As part of its advocacy efforts to ensure, to the greatest extent possible, that participants receive the benefit of ERISA's protections, AARP has participated as *amicus curiae* in cases concerning ERISA's benefit claims

efforts to promote independence, AARP works to foster the economic security of individuals as they age by attempting to ensure the availability, security, equity, and adequacy of public and private pension, health, disability and other employee benefits.

AARP's members and other participants in private employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA) to protect their rights. 29 U.S.C. § 1001 *et seq*. Because the quality of their lives depends heavily upon the security and amount of their pension, health, disability and other employee benefits, ERISA's protections, and the ability to enforce those protections, are of vital concern to older workers and retirees.

In order to ensure that they are receiving the benefits to which they are entitled, AARP members and other older persons must be able to successfully have access to, and resolve benefits disputes through, ERISA's claims procedure. In particular, these participants must know what the burden of production is for all parties, the weight their evidence will receive, and that they will receive all necessary information so that they can provide competent evidence of their claim and rebut evidence relied upon by the plan. If a plan does not provide the participant with the detailed reasons for its benefit denial as required under ERISA's claims procedure, participants cannot adequately protect their claims to benefits, which may spell the difference between independence and impoverishment in their old age.

(continued...)
process, *e.g., Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154 (9th Cir. 2001); *Juliano v. Health Maintenance Organization of New Jersey d/b/a U.S. Healthcare*, 221 F.3d 279 (2d Cir. 2000); as well as numerous other ERISA cases. *See, e.g., Rush-Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Pegram v. Herdrich*, 530 U.S. 211 (2000); *Varity Corp. v. Howe*, 516 U.S. 489 (1996).

AARP has a substantial interest in the resolution of the issues presented in this appeal. These issues have a direct and vital bearing on the ability of AARP members and other plan participants to have benefit claims fully and fairly reviewed as required by ERISA. Accordingly, AARP respectfully submits this brief *amicus curiae*.

SUMMARY OF ARGUMENT

At bottom, this case is about the fiduciary's conduct in reviewing the evidence the participant submitted to the plan to prove his right to receive disability benefits.[3/] Even if the plan provides the fiduciary with unfettered discretion, that discretion does not permit the fiduciary to ignore the participant's evidence without giving a rational reason for so doing. Here, the fiduciary gave no reason for rejecting the opinions of the treating physicians and the employer's human resource representative. ERISA and its claims regulation require more. ERISA § 503, 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1 (2003).

[3/] In this case, because the plan contends that it has no duty to provide the participant with the reasons it gave the treating physicians' opinions no weight, *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002), the Court need not decide whether the treating physician rule should be adopted as a substantive rule.

ARGUMENT

I. DETERMINING THE APPROPRIATE STANDARD OF REVIEW WHEN REVIEWING A BENEFIT CLAIMS DENIAL MAY REQUIRE A COURT TO LOOK BEYOND THE TERMS OF THE PLAN.

A. *Firestone* Recognized That a Denial of a Claim for Benefits Is Presumptively Reviewed under the *De Novo* Standard.

Relying on trust law, the Court held that "a denial of benefits challenged under 29 U.S.C. § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-12, 115 (1989). *De novo* review is always the standard of review unless discretion is clearly and unambiguously reserved. *See Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2170 (2002). ERISA does not provide by its terms, either directly or indirectly, for a deferential standard of judicial review of benefit denials. *Id.*

In *Firestone*, the Court went on to comment that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (citing RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1959)). In *Rush Prudential*, the Court flagged the open question now presented in this case of whether a plan provision providing for unfettered discretion in benefit determinations guarantees truly deferential review, especially "when the judicial eye is peeled for conflict of interest." 122 S. Ct. at 2169 n.15.

B. If the Fiduciary Acts from an Improper Motive, Then A Court Should Review the Plan Administrator's Decision *De Novo* Even If Plan Terms Provide for Unfettered Discretion.

The simple answer to the question raised by the Court in *Rush Prudential* is that trust law recognizes specific situations where even unfettered discretion is circumscribed so that a court will review a fiduciary's decision *de novo*. A conflict of interest is one of many factors in determining both whether a fiduciary has an improper motive or abused its discretion. RESTATEMENT (SECOND) OF TRUSTS § 187 cmts. d & g (1959).

RESTATEMENT (SECOND) OF TRUSTS § 187 (1959) provides specific situations when a fiduciary's discretion may be circumscribed. Among situations which may circumscribe a fiduciary's exercise of discretionary power granted by the terms of the trust are provisions in the law overriding plan terms; when the fiduciary acts dishonestly or with an improper, even though not dishonest, motive; when the fiduciary fails to use its judgment, breaches its fiduciary duty; or acts beyond the bounds of a reasonable judgment. *Id.* at cmts. a, d & i.

If the fiduciary has a conflict, the conflict should be considered in determining whether it has an improper motive. RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. g (1959). The Restatement of Trusts defines improper motive as one where the fiduciary "acts from a motive other than to further the purposes of the trust." *Id.* Such a motive may not necessarily be dishonest, but may be done out of "spite, prejudice or to further some other interest of his own or a person other than the beneficiary." *Id.* Where a fiduciary acts from an improper motive, a court will review its decision *de novo*.

Although a conflict may arise from various circumstances, the most common circumstance in an ERISA benefit claims denial case is where the insurer responsible for the benefit denial is both the funding source and the plan administrator. Most courts have found this circumstance to be an inherent conflict of interest in ERISA benefit claims denial cases. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 384 (3d Cir. 2000) (collecting cases). *See also, e.g., Lain v. UNUM Life Ins. Co.*, 279 F.3d 337 (5th Cir. 2002) (insurer's inherent, institutional conflict of interest infused into its employees by providing substantial financial bonus incentives); *Fox v. Fox*, 167 F.3d 880 (4th Cir. 1999) (former husband who also was administrator and refused to qualify former wife's qualified domestic relations order resulted in conflict).

However, the Ninth Circuit has recognized that under trust law such a conflict without more does not require a court to review the fiduciary's decision under the *de novo* standard.[4/] The Ninth Circuit employs a significantly more stringent standard: If the participant can show there is a conflict and produce evidence that tends to show that the conflict infected the decision to pay benefits, the burden then shifts to the fiduciary to show that its motive was not improper – that is, that its decision was made for reasons other than merely to avoid paying benefits. RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. g (1959). If the fiduciary cannot rebut the participant's showing, then the court should find that there is an improper motive – a failure to further the purposes of the trust to properly pay benefits to participants – and review the

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[4/] In some circuits, if the participant can show a conflict, the court will review the fiduciary's decision with heightened scrutiny. Depending on the extent of the conflict, the review will be more or less deferential. *See Pitman v. Blue Cross*, 217 F.3d 1291, 1295 (3d Cir. 2000) (finding that the greater the potential conflict, the greater the court's scrutiny of the benefit denial decision). Neither the plan nor the participant know what their burden of going forward is, the weight their evidence will receive, or the degree of scrutiny the benefit denial will receive. Clearly, such an approach is highly subjective.

fiduciary's decision *de novo*. *See Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556 (11th Cir. 1990) (shifting the burden to fiduciary to show that it is operating exclusively in the interests of the participants). This standard for determining whether there is an improper motive is consistent with the Restatement of Trusts, *see* RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. g (1959), and should be adopted by this Court.

II. A COURT MUST REVIEW ALL THE EVIDENCE IN THE RECORD TO ASSESS WHETHER THE PLAN CONSIDERED ALL SUCH EVIDENCE AND PROVIDED REASONS FOR DISCOUNTING EVIDENCE IT DID NOT RELY UPON TO DETERMINE IMPROPER MOTIVE.

A. The Evidence A Court Must Review to Determine Whether There Is Improper Motive Will Be Case Specific.

In looking at the evidence tending to show improper motive, participants will marshal, and courts will consider, all relevant evidence. Material probative evidence may include: a plan's inconsistent statements or actions, *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 799 (9th Cir. 1997); *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d at 1569; the failure of the plan to respond to evidence the participant submitted; insufficiency in the plan administrator's reasons, *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 977 (9th Cir. 1999); and procedural irregularities in the processing of the participant's claim. *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1110 (9th Cir. 1999); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998). A fiduciary may be able to rebut the participant's proof by showing that its decision was a benefit to all of the plan's participants. *See Yochum v. Barnett Banks, Inc.*, 234 F.3d 541, 546 (11th Cir. 2000) (fiduciary may justify decision on the ground that it benefits the class of all participants and beneficiaries). For example, the fiduciary

could show that its decision reflects a consistent interpretation of the plan and the plan denied benefit claims for similarly situated participants, resulting in a decision to avoid depletion of plan resources. *See, e.g., Pompano v. Michael Schiavone & Sons, Inc.*, 680 F.2d 911 (2d Cir. 1981) (trustees' decision not to grant discretionary lump sum payment benefitted participants by maintaining plan's financial integrity).

In this case, the Ninth Circuit considered, among other evidence, the plan's failure to deal with or respond to the treating physician's opinion. The court construed the failure to respond to the treating physician's opinion along with other evidence, including Black & Decker's own human resource representative, to indicate an improper motive to deny benefits.

In response to the Ninth Circuit's admonition that it could have produced sound reasons for its decision, the plan contended before the Ninth Circuit that it had "no duty to consider evidence that was unfavorable to its determination, whether coming from Nord's physicians or from its own human resources representative." *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002). The plan's response is extremely disturbing and disingenuous, given ERISA's requirements.

Under this plan's viewpoint, it would never have to look at any information provided by the participant if it was favorable to the participant. This viewpoint leads inexorably to the conclusion that a plan could grant or deny benefits totally at will. This is no standard at all.

B. In Order to Ensure That Participants Will Receive a Full And Fair Review, ERISA's Claims Procedure Requires That The Plan Provide The Participant With Specific Reasons For Denying The Claim And Not Relying Upon Evidence Favorable to The Participant.

Among the safeguards that Congress enacted was a claims procedure to resolve disputes over benefit claims. ERISA § 503, 29 U.S.C. § 1133. Section 503 provides that when a participant's claim for benefits has been denied, a benefit plan shall provide adequate written notice to the participant, setting forth the specific reasons for the denial, written in a manner to be understood by the participant.[5] *Id.* Section 503 also states that the plan shall provide the participant with a reasonable opportunity for a full and fair review of the benefit denial. 29 U.S.C. § 1133. The claims procedure provides that the plan must provide specific information to participants if their benefit claims are denied. 29 C.F.R. § 2560.503-1(f) (1977).

In issuing its regulation interpreting Section 503, the Department of Labor unambiguously furthered Congress' intention to furnish participants with procedural safeguards for their benefits. "[T]he rules [for the claims procedure] are designed to insure that plan participants and beneficiaries have their claims for benefits handled by their plans in a fair way." Claims Procedure for Employee Benefit Plans, 42 Fed. Reg. 27,426 (May 27, 1977).[6] This claims procedure

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[5] Section 503's disclosure requirements are consistent with ERISA's objective of providing full disclosure to participants. ERISA § 2(a), 29 U.S.C. § 1001(a). Congress realized that only full disclosure would enable participants to vindicate their rights. *See* S. REP. NO. 93-127 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4863.

[6] *Nord* was decided under the 1977 regulations. In 2000, revised regulations were issued, maintaining the protections under the 1977 regulations and, in many instances, conferring additional safeguards. *See* Minimum Requirements for Benefit Claims Procedures, 65 Fed. Reg. 70246

regulation requires that the initial notice of a claims denial contain: (1) the specific reason(s) for the denial; (2) specific reference to pertinent plan provisions upon which the denial is based; (3) a description of additional materials or information necessary for the participant to perfect the claim and an explanation of the reason such material or information is necessary; and (4) appropriate information as to the steps to be taken if the participant desires to submit the claim for review. 29 C.F.R. § 2560.503-1(f) (1977).[7/] The regulation also requires that a plan have an internal review procedure, which allows participants or their representative to request review, review pertinent documents, and submit comments in writing. 29 C.F.R. § 2560.503-1(g) (1977).[8/]

The purpose of these regulations is to provide participants with the information needed for a meaningful review of their denial of benefits: an adequate explanation of the denial of benefits, a record of what evidence the plan relied upon in denying the benefit, an opportunity to address the accuracy and reliability of that evidence, and an opportunity to have the plan consider the participants' evidence prior to reaching its decision. *Grossmuller v. International Union*, 715 F.2d 853, 858 n.5 (3d Cir. 1983). The reasons for the required information are to ensure participants that their claims are handled fairly, Claims Procedure for Employee Benefit Plans, 42 Fed. Reg. 27,426 (May 27, 1977); to provide participants with the information needed for a meaningful review of their denial of benefits so that they can address the determinative issues, *see Grossmuller*, 715 F.2d at 857-59; to reduce frivolous appeals, *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980); and to enable participants to prepare adequately for further administrative review and appeal to

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(Nov. 21, 2000) (codified at 29 C.F.R. pt. 2560).

[7/] These requirements are found in the 2000 regulations under 29 C.F.R. § 2560.503-1(g) (2000).

[8/] These requirements are found in the 2000 regulations under 29 C.F.R. § 2560.503-1(h) (2000).

the federal courts if necessary. *See Richardson v. Central States, Southeast & Southwest Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981); *accord*, *Halpin v. Grainger, Inc.*, 962 F.2d 685, 689 (7th Cir. 1992). These requirements also ensure that when participants appeal their denials to the plan administrator, they will be able to address the determinative issues. Thus, these requirements "enable[] a participant both to appreciate the fatal inadequacy of his claim as it stands and to gain a meaningful review by knowing with what to supplement the record." *Wolfe v. J.C. Penney Co.*, 710 F.2d 388, 392 (7th Cir. 1983).

"In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). Only a plan knows the reasons for the benefit denial, the information which participants need to perfect their claims, and the information and documents upon which the plan relied to make its decision. Participants do not have this knowledge. Without an exchange of information, the trustees will not have had the opportunity to fully consider the participants' arguments and evidence. Nor will they have had the opportunity to refine the issues. In addition, trustees will have the opportunity to ensure that they have treated benefit claims consistently and minimize the costs of settlement. *Amato*, 618 F.2d at 568. A plan must meet these minimum requirements of the regulation so that participants receive full and fair review of their claim for benefits.

In this case, the plan's failure to provide the reasons it rejected the opinions of the treating physicians and human resource representative should be enough for any court to find improper motive.

C. The Treating Physician's Opinion Should Be Accorded Significant Weight Unless the Plan Provides Specific Legitimate Reasons for Not Doing So.

The treating physician's opinion will be one of the most important pieces of evidence that the participant submits to the plan in support of the claim for benefits. In order to prove the participant's entitlement to disability pension, health or disability benefits, the treating physician must provide the plan with the reasons he or she concludes that the participant needs a certain medical treatment or makes a diagnosis which draws conclusions about the ability of the participant to work. Given the regulatory requirement that a plan provide the reasons a benefit claim is denied, it certainly would seem suspicious to a court if a plan provides no response to this crucial piece of evidence.

Under this burden shifting approach, the treating physician's opinion does not trump all other evidence, but it must be given appropriate weight. *Conley v. Pitney Bowes*, 176 F.3d 1044, 1049 (8th Cir. 1999). To determine the appropriate weight to give the treating physician's opinion, the plan must thoroughly review, consider, and analyze the treating physician's opinion. If the plan chooses not to rely upon the opinion or reject it, it must provide the participant with the reasons for so doing so that the participant may respond. The plan may reject or discount the treating physician's opinions for a myriad of reasons.[2/] *See, e.g.*, *Wallace v. Reliance Standard Life Ins. Co.*, 318 F.3d 723

[2/] Petitioner and some of its *amici* contend that the treating physician's opinion should be discounted because some treating physicians may not be objective in giving their opinions due to potential financial gain. Likewise, similar allegations have been made by participants concerning physicians who review cases for insurers and plans. *See, e.g., Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 203 U.S. App. LEXIS 937, *32 (6th Cir. 2003). The appropriate method of handling this issue is not to say "a pox on both of your houses," but to permit a party to submit evidence in the record to demonstrate that a particular physician's opinion is "tainted."

(7th Cir. 2003) (treating physician stated no longer disabled; fiduciary under no obligation to obtain additional information); *Fletcher-Merrit v. Noram Energy Corp.*, 250 F.3d 1174 (8th Cir. 2001) (treating physician's opinion not entitled to greater weight where his opinion based on opinions of non-treating doctors); *Gooden v. Provident Life & Acc. Ins. Co.*, 250 F.3d 329 (5th Cir. 2001) (treating physician's opinions were contradictory); *Heaser v. The Toro Co.*, 247 F.3d 826 (8th Cir. 2001) (treating physicians disagreed as to disability status); *cf. Newcomb v. Standard Ins. Co.*, 187 F.3d 1004 (9th Cir. 1999) (treating physicians had special expertise in diagnosis of this particular disability as compared with insurer's physician; therefore more weight was appropriate). The ultimate decision to determine whether benefits should be granted or denied still rests with the fiduciary after full consideration of all the evidence in the record. *See Crocco v. Xerox*, 956 F. Supp. 129, 138-42 (D. Conn. 1997), *aff'd*, 137 F.3d 105, 108 (2d Cir. 1998) (no full and fair review because administrator relied on third party without making an independent review of record and weighing all physicians' opinions).

Responding to the treating physician's opinions is simply the manner in which the claims process works. Not only is the failure to provide the participant with any reasons the plan is rejecting or discounting the treating physician's opinion a violation of the requirements of the claims procedure, but it also raises the issue of whether the plan fiduciary has breached its fiduciary duties by not administering the plan correctly. *See Friedrich*, 181 F.3d 1105 at 1110 (the presence of procedural irregularities in the initial claims process or the appeals process can demonstrate that a breach of fiduciary duty may have taken place).

Ignoring the treating physician's opinion here is evidence that would tend to show that the decision to deny benefits was made from an improper motive. If the plan does not rebut the evidence tending to show that there was an improper motive by showing that the same decision would have been made regardless of the conflict or improper motive

– like the plan's failure to do so here – then the court should review to decision to deny benefits *de novo*.

CONCLUSION

For the foregoing reasons, AARP urges the Court to affirm the Ninth Circuit's decision.

March 28, 2003

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IN THE

Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,
Petitioner,

v.

KENNETH L. NORD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICUS CURIAE*

The American Medical Association ("AMA") submits this brief *amicus curiae* in support of respondent.[1] The AMA, an Illinois not-for-profit corporation founded in 1847, is the largest medical society in the United States. Its approximately 260,000 physicians practice in all fields of medical specialization in every state. The AMA is dedicated to promoting the science and art of medicine and the betterment of public health.

The AMA has a unique perspective on the standard of review that should apply under the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.* ("ERISA"), to eligibility decisions by employee health and welfare plan administrators who operate under conflicts of interest. Every day, physicians throughout this nation are called upon to make judgments regarding whether impairments render their patients disabled under the terms of private health and welfare plans governed by ERISA. These medical judgments by treating physicians are frequently subject to review by plan administrators and by physicians and other health care professionals engaged by those plans. The degree of deference accorded to the medical judgments of treating physicians in these reviews is a matter of substantial importance to these treating physicians – and, more significantly, to the patients for whom they care. For these

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[1] Counsel for the AMA authored this brief in its entirety. The AMA files this brief as a member of the American Medical Association/State Medical Society Litigation Center ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts. No monetary contributions to the preparation or submission of this brief were received from any other source. Sup. Ct. R. 37.6. The parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court. *Id.* 37.3.

reasons, the AMA and its members have a direct interest in the question presented by this case, *i.e.*, the extent to which the fiduciary obligations of a plan to its beneficiaries require a plan administrator to respect the medical judgment of the physician who is responsible for the care of the beneficiary.

In its submission to this Court, petitioner argues that treating physicians frequently engage in deception and exaggeration so that patients can obtain benefits to which they are not entitled. This portrayal of the medical profession is grossly inaccurate and unfair and should play no role in the resolution of the important issue this case presents. A presumption that treating physicians accurately assess their patients' conditions and needs in accordance with the patients' best interests is amply justified by both empirical evidence and by the ethical precepts of the medical profession. Indeed, the ethical obligations of a treating physician closely parallel a plan administrator's fiduciary obligation under ERISA to act in the best interests of beneficiaries. 29 U.S.C. § 1104(a).

In light of that close parallel, when reviewing benefit denials by administrators operating under the conflict of interest that arises when employers both fund and administer plans, courts should apply a modified version of the "treating physician rule" developed in the Social Security context. In particular, a treating physician's judgment concerning the nature of an impairment should be honored unless the plan administrator articulates a substantial basis for deviating from that judgment. This modified treating physician rule helps conflicted ERISA fiduciaries check the impermissible influence of their own financial interest to limit disability payments and ensures that ERISA's abuse of discretion standard plays a meaningful role in detecting and preventing misuses of discretionary authority. At the same time, such a treating physician rule should not unduly interfere with the discretion of administrators in administering plans.

STATEMENT OF THE CASE

Respondent Nord was treated by several physicians in connection with the lower back pain that gave rise to his disability claim. Leo Hartman, M.D., an internist who had treated respondent for several years before the onset of Nord's back condition, diagnosed respondent as suffering from "Lumbar Disc. syndrome." Petitioner's Lodging ("L.") 81, 84. Dr. Hartman based that diagnosis both on physical examinations and on MRI results that revealed degenerative changes of the lower lumbar spine and degenerative disc disease.

Dr. Hartman also referred Nord to Ismael Silva, M.D., an orthopaedic surgeon. Dr. Silva examined the patient on a number of occasions, L. 84-94, and prescribed various pain medications. L. 105-08, 111-12 (copies of prescriptions). Dr. Silva also referred Nord to Dr. Ali for nerve conduction studies and an EMG. Dr. Ali diagnosed the patient with "mild bilateral L5 radiculopathy." L. 97-99 (capitalization omitted). Dr. Hartman also referred Nord to Lytton Williams, M.D., another orthopaedic surgeon, who recommended surgery. L. 43

All of Nord's treating physicians agreed that the patient suffered from degenerative disc disease. Nord underwent physical therapy, including pelvic traction, beginning in August 1997. L. 85-86, 118, 152; see also *id.* at 104, 106, 109-10, 113. Dr. Hartman's notes also reflect that Nord took various medications for his back pain during the summer and fall of 1997. L. 56, 58-59. Despite these measures, Dr. Hartman's notes indicate that Nord's back had not improved and that his pain persisted. L. 55-56. Dr. Silva's notes likewise indicate that, although medication "help[ed]" the patient "tolerat[e]" his pain, L. 87, 89, the pain continued months after he began taking medications and after he underwent traction. See L. 94 (medications prescribed August 15, 1997); L. 87 (noting, nearly five months later, that

Nord was still taking medications and that back pain continued); L. 92, 93 (noting increased pain during period of traction therapy).

While undergoing treatment for his back, Nord filed a claim for disability benefits. The plan administrator, through its agent Metropolitan Life Insurance Company ("MetLife"), rejected that claim in February 1998. MetLife stated that, based on its review of the medical documentation respondent had submitted, his condition "would not preclude [him] from performing [his] job at Black and Decker." L. 145. In support of this conclusion, MetLife cited Nord's ability to take care of his lawn and to do some housework, as well as an office note from Dr. Silva indicating that respondent was "able to tolerate [his] pain with medications." L. 144.

Nord continued to seek treatment for his condition, seeing both Dr. Hartman and Dr. Williams in the spring of 1998. Pet. App. 22-23. In March 1998, Nord underwent a lumbar discogram and CT scan that revealed annular thinning of the intervertebral discs and loss of disc space. L. 51. In April 1998, both physicians completed physical capacity evaluations in which they concluded that Nord could sit for only one hour a day and could lift no more than five pounds. Pet. App. 23.

During this same period, Nord also sought review of the denial of his benefits claim. In connection with that appeal, MetLife arranged to have respondent examined by a neurologist, Dr. Mitri. Dr. Mitri agreed that Nord was suffering from degenerative disc disease, as well as chronic myofascial pain syndrome. Dr. Mitri opined, however, that, "[r]eviewing the patient's job description, and on the basis of the general examination and neurological examination, and after reviewing the report of his tests, I think the patient should be able to do sedentary work with some interruption by walking in between." L. 45. Dr. Mitri further opined that "all the work up that was done did not really show any evidence to substantiate disability in doing sedentary work

with some walking interruption in between." *Id.* Dr. Mitri failed to address the lumbar discogram or the CT scan Nord had undergone a few months earlier, and he offered no further explanation for why he disagreed with the views of Nord's treating physicians, who had each concluded that their patient could not sit for more than one hour each day.

MetLife rejected respondent's appeal, and Black & Decker adopted that denial in a letter dated October 27, 1998. Black & Decker explained that, although Dr. Mitri diagnosed respondent as suffering from degenerative disc disease, as well as chronic myofascial pain syndrome, respondent's "general and neurological examination are essentially normal." L. 156. Black & Decker stated that the tests performed "essentially show no evidence of lumbosacral nerve root compression," and that, although an "EMG and NCS showed bilateral L5 radiculopathy, this was stated to be mild and was not confirmed by the LS MRI that did not show root compression." *Id.* Like Dr. Mitri, Black & Decker did not explain why it disagreed with the conclusion of respondent's treating physicians, nor did it mention the lumbar discogram or the CT scan.

SUMMARY OF ARGUMENT

An ERISA plan administrator owes an "unwavering duty" of loyalty to employees and their beneficiaries. *NLRB* v. *Amax Coal Co.*, 453 U.S. 322, 329 (1981); 29 U.S.C. § 1104(a). However, when a single entity functions as both a funding source and an administrator, it is operating under a conflict of interest. This Court has required that courts pay special attention to such conflicts of interest, *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 115 (1989), and this critical scrutiny tempers the deference that would otherwise be accorded to a plan administrator executing its discretionary powers. The treating physician rule, which in the ERISA context requires that a plan administrator give an adequate reason if it rejects the opinion of a treating physician,

provides an important means of ensuring that the conflicted administrator has acted consistently with its fiduciary duties. Such presumptive deference to the treating physician implements the ERISA rules articulated by the Department of Labor and imposes no significant additional burden on plan administrators.

Contrary to petitioner's assertions, the rule is well-established in the Social Security context and justified by the medical literature, which shows that treating physicians often have the most information on their patients' conditions, based on their ongoing treatment relationship with the patient. In addition, the rule is supported by a treating physician's ethical duties to act in the patient's best interests. Indeed, the treating physician's fiduciary duty to his or her patient parallels the fiduciary duty owed by the plan administrator to the employee or beneficiary; presumptive deference to the treating physician's opinion thus acts as a check on dual loyalties that may impair a conflicted plan administrator's judgment.

In this case, the plan administrator did not explain why it was rejecting the opinions of Nord's treating physicians, who diagnosed Nord with degenerative disc disease and stated that Nord was unable to sit for more than an hour a day or lift more than five pounds. Nord's job description required him to sit for up to six hours a day and to lift up to twenty pounds. Nevertheless, the doctor hired by the plan administrator to review Nord's claim, Dr. Mitri, declared that Nord was not disabled and could perform his job. The plan administrator denied Nord disability benefits and gave no substantial basis for preferring Mitri's assessment over the treating physicians' conclusions that Nord's disease prevented him from meeting certain basic requirements of his job description. The failure to explain why it was rejecting the opinions of Nord's treating physicians constituted an abuse of the conflicted plan administrator's discretion, and the judgment of the Ninth Circuit should be affirmed.

ARGUMENT

In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989), this Court held that courts should generally apply a deferential abuse of discretion standard when reviewing discretionary decisions by plan administrators and other fiduciaries, but indicated that a more searching inquiry should apply where a fiduciary acts under a conflict of interest. In this case, the plan administrator was operating under a conflict of interest because it both funded the plan and made benefits decisions under the plan. A rule that requires such a conflicted administrator to provide an adequate explanation when rejecting the presumptively valid views of a treating physician helps to focus the careful inquiry that this Court has required, and ensures that such administrators do not abuse their discretion or violate their fiduciary obligations to beneficiaries.

I. TO ENSURE COMPLIANCE BY ERISA PLAN ADMINISTRATORS WITH THEIR STATUTORY FIDUCIARY DUTY TO ACT SOLELY IN THE INTEREST OF BENEFICIARIES AND PARTICIPANTS, COURTS SHOULD CAREFULLY SCRUTINIZE BENEFIT DENIALS BY ADMINISTRATORS WITH CONFLICTS OF INTEREST.

"ERISA was enacted to promote the interests of employees and their beneficiaries" as participants in employee benefit plans and "to protect contractually defined benefits." *Firestone*, 489 U.S. at 113 (internal quotation marks and citations omitted). To help achieve these "broadly protective purposes," Congress "commodiously imposed fiduciary standards on persons whose actions affect the amount of benefits . . . plan participants will receive," *John Hancock Mut. Life Ins. Co.* v. *Harris Trust & Sav. Bank*, 510 U.S. 86, 96 (1993), including any person who has "any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A). A plan admini-

strator must "discharge his duties with respect to a plan *solely in the interest of the participants and beneficiaries* and – (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries." *Id.* § 1104(a) (emphasis added).

As this Court has repeatedly recognized, this standard is a stringent one. "ERISA essentially codified the strict fiduciary standards that a [management trustee appointed under § 302(c)(5) of the Labor Management Relations Act] must meet." *NLRB* v. *Amax Coal Co.*, 453 U.S. 322, 332 (1981). Those standards require "an unwavering duty of complete loyalty to the beneficiary of the trust, to the exclusion of the interests of all other parties," and this duty of loyalty "must be enforced with uncompromising rigidity." *Id.* at 329-30 (citation and internal quotation marks omitted). See also *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 152-53 (1985) (Brennan, J., concurring) ("fiduciaries owe strict duties running directly to beneficiaries in the administration and payment of trust benefits"); *Varity Corp.* v. *Howe*, 516 U.S. 489, 539 (1996) (Thomas, J., dissenting) (describing ERISA's fiduciary standards as "strict"); 120 Cong. Rec. 29929 (1974) (remarks of Sen. Williams) (ERISA imposes "strict fiduciary obligations upon those who exercise management or control over assets or *administration* of an employee pension or welfare plan") (emphasis added).

Drawing on established principles of trust law, this Court has ruled that decisions of plan administrators and other fiduciaries who are exercising discretionary authority to determine eligibility for benefits are generally to be reviewed under an abuse of discretion standard. *Firestone*, 489 U.S. at 115. This deferential standard of review is appropriate where administrators are properly presumed to exercise their discretion in the best interests of participants and beneficiaries. This general presumption – and any judicial deference that flows from it – is unwarranted, however, where a plan vests discretionary authority in an administrator who

has an inherent conflict of interest. A plan administrator who is both the funding source and the decision-maker for the plan operates under a financial conflict of interest. A fiduciary who has dual loyalties "'cannot act exclusively for the benefit of a plan's participants and beneficiaries,'" *Amax Coal*, 453 U.S. at 334 (quoting H.R. Conf. Rep. No. 93-1280, 309 (1974)), and "cannot contend that, although he had conflicting interests, he served his masters equally well or that his primary loyalty was not weakened by the pull of his secondary one." *Id.* at 330 (citations and internal quotation marks omitted). Accordingly, this Court has held that, where a plan vests discretion in "an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Firestone*, 489 U.S. at 115 (alteration in original) (quoting *Restatement (Second) of Trusts* § 187, cmt. d (1959)).

In this case, "the employer's dual role in funding the plan and deciding claims under it created a conflict of interest that triggered a requirement of more searching judicial review under *Firestone*." Brief of United States as *Amicus Curiae* ("U.S. Br.") at 27. The court below so held, and petitioner did not seek review of that ruling in this Court. As explained below, a properly defined "treating physician" rule is necessary to ensure that a conflicted administrator has, in fact, acted out of "an unwavering duty of complete loyalty to the beneficiary." *Amax Coal*, 453 U.S. at 329.

II. THE TREATING PHYSICIAN RULE, AS MODIFIED IN THE ERISA CONTEXT, IS NECESSARY TO ENSURE THAT CONFLICTED PLAN ADMINISTRATORS PROPERLY DISCHARGE THEIR STATUTORY FIDUCIARY DUTIES TO BENEFICIARIES.

In *Firestone*, this Court did not specify how courts should conduct the more searching review that is required when a plan administrator operating under a conflict of interest denies

a benefits claim. In such circumstances, a plan administrator should be required to provide a substantial written explanation for rejecting the views of a treating physician, and courts should treat an administrator's failure to provide such an explanation as an abuse of discretion. Such a rule flows from the language of both § 1104 and § 1133 and ensures that a conflicted administrator has adequately considered the views of treating physicians, who are obligated (like fiduciaries themselves) to act in the patient's best interests. Such a rule thus serves as a critical check on discretionary benefit denials by administrators laboring under improper "dual loyalties," without unduly burdening administrators or otherwise undermining ERISA's goals.

A. A Treating Physician's Views Are Properly Presumed To Reflect The Patient's Best Interests.

Both the ethical obligations of treating physicians and the empirical data support a rebuttable presumption that a treating physician's views reflect the patient's best interests. In fact, the ethical obligations of physicians to their patients closely mirror the strict duties a fiduciary owes beneficiaries under ERISA. Just as an ERISA fiduciary owes "an unwavering duty of complete loyalty to the beneficiary. . . , to the exclusion of the interests of all other parties," *Amax Coal*, 453 U.S. at 329, treating physicians must "plac[e] patient welfare before all other concerns," and may not, under any circumstances, "place their own financial interests above the welfare of their patients." AMA, *Code of Medical Ethics*, Ops. 8.02, 8.03, *available at* http://www.ama-assn.org/ama/pub/category/2503.html (last updated July 31, 2002); see also *id.* Op. 10.015 (treating physicians have "ethical obligations to place patients' welfare above their own self-interest[s]"). Indeed, a central tenet of medical ethics is that a physician "shall, while caring for a patient, regard responsibility to the patient as paramount." AMA, *Principles of Medical Ethics*, Principal VIII, *available at* http://www.ama-assn.org/ama/pub/category/2512.html (last updated Apr. 2, 2002). Thus,

"[w]ithin the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount." AMA, *Code of Medical Ethics*, Op. 10.015.

In addition to these ethical obligations, treating physicians typically have on-going relationships with the patient and are thus very familiar with the patient's physical and psychological condition, the patient's tolerance for pain, and the patient's ability to benefit from alternative approaches to treatment. In particular, the evaluation of pain, for which there are no objective medical tests, draws on a treating physician's relationship with a patient, for measurement of pain depends on a patient's full communication with the doctor. See 1 *Harrison's Principles of Internal Medicine* 1 (15th ed. 2001) ("*Harrison's Principles*"); *Textbook of Primary Care Medicine* 93 (John Noble ed., 3d ed. 2001) (discussing the patient's report of pain as "the most reliable information available"). Medical literature is clear that patient-physician communication is more thorough and candid in an ongoing physician-patient relationship. See, *e.g.*, Susan A. Flocke et al., *The Impact of Insurance Type and Forced Discontinuity on the Delivery of Primary Care*, 45 J. Fam. Prac. 129, 132 (1997). Moreover, a treating physician's relationship with the patient over time permits the physician to evaluate effectively the results of various treatments and medications on the patient's pain and ability to function.

Recognizing the important insights that a treating physician's relationship to a patient can provide, the federal government has itself endorsed a presumption that the views of treating physicians are valid. Since 1991, regulations promulgated by the Commissioner of Social Security have provided that, in evaluating medical opinion evidence regarding disability determinations, the Commissioner will generally give more weight to opinions from treating physicians because "these sources are likely to be the medical professionals most able to provide a detailed, longitudinal

picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations." 20 C.F.R. § 404.1527(d)(2). Although the Commissioner's views are not binding here, the well-reasoned views of an agency implementing a statute that also governs disability determinations "constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." *Bragdon* v. *Abbott*, 524 U.S. 624, 642 (1998) (referring to views of agencies not entitled to *Chevron* deference; internal quotation marks and citation omitted).

The presumptive validity of treating physician views is supported not only by the "experience and informed judgment" of an agency administering a comparable disability program, but by empirical evidence as well. Studies show that continuity of care leads to better patient outcomes. See, *e.g.*, Margaret M. Love et al., *Continuity of Care and the Physician-Patient Relationship: The Importance of Continuity for Adult Patients with Asthma*, 49 J. Fam. Prac. 998 (2000). One such study found that:

> [w]hen patients concentrate their care with a single physician, those physicians are more likely to develop an accumulated knowledge about their patients' medical conditions. This knowledge goes beyond simply knowing the patient's diagnoses and medications. It includes a finer understanding of the severity of each medical problem and how multiple problems interact.

Id. at 1003. Other studies provide additional support for the conclusion that there is a correlation between the quality of primary care and continuity of the patient-physician relationship, see Flocke, *supra*, at 132-33, and that physicians' knowledge of patients is a leading correlate of improved health status. See Dana G. Safran et al., *Linking*

Primary Care Performance to Outcomes of Care, 47 J. Fam. Prac. 213 (1998).

In short, in light of this empirical evidence, as well as the close parallels between the obligations of treating physicians and ERISA fiduciaries to patient-beneficiaries, it is reasonable to assume, in the first instance, that a treating physician's opinion reflects the patient's best interests.

B. A Conflicted Administrator's Failure To Provide An Adequate Written Explanation For Rejecting The Presumptively Valid Views Of A Treating Physician Constitutes An Abuse Of Discretion.

Any presumption that the views of a treating physician are valid must be a rebuttable one. Thus, a conflicted plan administrator is not required to accept the treating physician's opinion. Such an administrator could, for example, reject the treating physician's opinion because the opinion is not "accompanied or supported by objective or clinical findings," because the treating physician "lacked [the] relevant expertise," or because additional medical evidence, such as laboratory results, undermines the treating physician's diagnosis.[2] See U.S. Br. at 15. But the conflicted administrator should set forth these or any other reasons for rejecting the presumptively valid views of a treating physician in a written explanation that the beneficiary and a court may review, and a conflicted administrator's failure to provide an adequate explanation for rejecting the treating physician's views should be treated as an abuse of discretion.

Such requirements advance ERISA's purposes in several ways. First and foremost, the requirement of an adequate

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[2] Such reasons will typically be provided by a physician hired by the plan to conduct an independent medical examination and to review the patient's medical records. Any presumption in favor of the validity of the views of treating physicians, therefore, is not intended to disparage the views of independent medical examiners, who can provide the adequate reasons necessary to rebut that presumption.

written explanation serves as a check on any impermissible influence that the administrator's divided loyalties might otherwise exert on a benefit decision. The obligation to provide a substantial written explanation ensures that a conflicted administrator who is statutorily obligated to act in the beneficiary's best interests actually considers the medical opinion rendered by the treating physician. Indeed, such a requirement helps conflicted administrators themselves guard against unconscious bias. The very exercise of explaining a decision to reject a treating physician's opinion forces the plan administrator to confirm that the decision is based on appropriate medical evidence and the relevant decisional factors. An inability to cite substantial reasons in support of a decision to deviate from a finding of the treating physician regarding impairment of the patient should serve as a warning to fiduciaries that their decisions may be based on improper incentives.

Second, the requirement of a written explanation setting forth a substantial reason ensures that ERISA's abuse of discretion standard plays a meaningful role in detecting and preventing misuses of discretionary authority by fiduciaries. ERISA requires that employee benefits plans "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(1). A requirement that this statutorily mandated explanation set forth a substantial reason for rejecting the treating physicians' views is analogous to requirements under the Administrative Procedure Act ("APA") that federal courts have long used to ensure the adequacy and propriety of decision-making by entities possessing discretion and substantive expertise. In reviewing the adequacy of a conflicted administrator's decision, courts will be able to ensure that the administrator "examine[d] the relevant data and articulate[d] a satisfactory explanation for

[his] action including a 'rational connection between the facts . . . and the choice made.'" *Motor Vehicle Mfrs. Ass'n* v. *State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (quoting *Burlington Truck Lines, Inc.* v. *United States*, 371 U.S. 156, 168 (1962)). Where conflicted administrators cannot satisfy this standard, courts can properly ascribe the failure to the impermissible influence of the conflict, and should invalidate the decision as an abuse of discretion. This "narrow" yet "'searching and careful'" form of review, *Bowman Transp., Inc.* v. *Arkansas-Best Freight Sys., Inc.*, 419 U.S. 281, 285 (1974), thus enables courts to detect deviations from ERISA's strict fiduciary standards.[3]

C. The Arguments Of Petitioner And Its *Amici* Provide No Basis For Rejecting The Treating Physician Rule.

1. The Medical Literature Petitioner Cites Does Not Justify Judicial Rejection of the Treating Physician Rule.

Petitioner argues at length that any presumption that a treating physician's views are correct is a "fallacious," "erroneous" and "outdated stereotype" that has "no place in today's medical managed care marketplace." Petitioner's Br. at 27, 28 and 33 (capitalization omitted). As the AMA has already demonstrated, however, petitioner's bald assertion that "[t]here is no empirical evidence that supports" such a presumption is untrue. See *supra* at 12-13. As just noted, the presumption might be rebutted in appropriate circumstances. See *supra* at 13. But petitioner's broad-based and misguided

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[3] Most courts of appeals already require plan administrators to engage in reasoned decision making when denying a claim. *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3d Cir. 2000); *Donaho* v. *FMC Corp.*, 74 F.3d 894, 899 (8th Cir. 1996); *Pagan* v. *NYNEX Pension Plan*, 52 F.3d 438, 442 (2d Cir. 1995); *but see Gallo* v. *Amoco Corp.*, 102 F.3d 918, 922 (7th Cir. 1996) (noting in dicta that "[t]here is no such requirement [to articulate the grounds for a plan administrator's decision] in the law").

attack on the integrity of the entire medical profession provides no basis for refusing to recognize a rebuttable presumption in the first place. Indeed, in making that attack, petitioner not only mischaracterizes the medical literature, but fails to recognize that a treating physician's role as an advocate for her patient furthers ERISA's goals.

Citing several surveys, petitioner contends that physicians will often lie or exaggerate in order to deceive insurers and obtain benefits for their patients. Petitioner's Br. at 29-33. Only one of these surveys, however, examined actual practices, rather than reactions to hypotheticals,[4] and this survey reported that the vast majority of physicians believe it is morally wrong to "game the system" for a patient's benefit (85%) and unnecessary to do so in order to provide high-quality care (71.5%). Matthew K. Wynia et al., *Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 283 J. Am. Med. Ass'n 1858, 1862, tbl.2 (2000). These views "accord[] with the strongly worded official declarations of professional societies, wherein manipulating reimbursement rules is considered an ineffective and socially irresponsible way to advocate for patients' interests." *Id.* at 1863; see also AMA, *Code of Medical Ethics*, Op. 9.132 (encouraging physicians "to play a key role in identifying and preventing fraud" and exposing "those physicians . . . who engage in fraud or deception.").

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[4] *See* Dennis H. Novack et al., *Physicians' Attitudes Toward Using Deception To Resolve Difficult Ethical Problems*, 261 J. Am. Med. Ass'n 2,980, 2,985 (1989) (seeking response to four hypothetical problems, and noting that the study's "response rate and limited scope *preclude generalizations* about the prevalence and nature of physician deception") (emphasis added); Victor G. Freeman et al., *Lying for Patients: Physician Deception of Third-Party Payers*, 159 Archives Internal Med. 2263, 2270 (1999) (employing 6 hypothetical vignettes, and noting that authors were "unsure of the extent to which" the respondents' willingness to sanction deception in the vignettes "translates into the actual use of deception in practice").

Indeed, the majority of physicians surveyed (61%) reported that they never or rarely misrepresented a patient's symptoms, diagnosis, or severity of illness, even to obtain "coverage for care that the physicians perceive to be *necessary*." Wynia, *supra*, at 1863 (emphasis added). This unwillingness to deceive even to obtain necessary care is particularly significant, because a treating physician can be found negligent for failing to provide necessary care even where an insurer refuses to pay for it.[5] Thus, the very data petitioner cites does not support its sweeping claim that most treating physicians will intentionally misrepresent a patient's condition in order to help the patient obtain benefits for medically necessary treatment, let alone disability benefits that are not essential to the discharge of the physician's legal and ethical obligations to furnish needed medical care.

Petitioner also suggests that any presumption that a treating physician's diagnosis is accurate or valid is fatally undermined by the treating physician's role as a patient advocate. Petitioner's Br. at 31-33. But a treating physician's duty "to advocate for [the] patient's welfare," AMA, *Code of Medical Ethics*, Op. 10.015, is merely an outgrowth of "the imperative to care for patients and to

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[5] *See generally* E. Haavi Morreim, *Gaming the System: Dodging the Rules, Ruling the Dodgers*, 151 Archives Internal Med. 443, 444 (1991) (noting that the governing standard of care requires use of appropriate technologies, regardless of who pays for them); Peter D. Jacobson & Scott D. Pomfret, *ERISA Litigation and Physician Autonomy*, 283 J. Am. Med. Ass'n 921, 923 (2000) (noting that ERISA preemption of many state law claims alleging that managed care organization's denial or delay in care caused an adverse medical outcome means that "the patient's only remedy is to sue the physician, regardless of how much influence over the clinical decision the physician actually exercised"); James S. Forrester et al., *Task Force 1: External Influences on the Practice of Cardiology*, 31 J. Am. Coll. Cardiology 926, 929 (1998) ("ERISA, therefore, creates a unique dichotomy in which the physician may assume the liability for a plan's decision with which he or she does not agree, while the plan's nonphysician decision maker is protected from liability.").

alleviate suffering," *id.* It is this same imperative that gives rise to the physician's obligation "to use sound medical judgment, holding the best interests of the patient as paramount." *Id.* Thus, physicians are "advocates" not for their patients' *pecuniary* interests, but for their patients' *physical and psychological* well-being. The diagnoses of treating physicians are entitled to a presumption of validity, therefore, precisely because these physicians are obligated to furnish the medical care that is in their patients' best interests.

Indeed, the fact that treating physicians must act as advocates for the medical care that is best for their patients militates in favor of judicial recognition of a treating physician rule under ERISA. ERISA requires plan administrators to act out of an unwavering loyalty to, and "solely in the interest of," participants and beneficiaries. 29 U.S.C. § 1104(a). Because ERISA's fiduciary duty of loyalty so closely parallels a treating physician's ethical obligations, courts as well as plan administrators should presume that the diagnosis of a treating physician reflects the best interests of the patient, and that a conflicted administrator's failure to offer an adequate explanation for rejecting that diagnosis constitutes an abuse of discretion.

2. Federal Regulations Support, Rather Than Undermine, the Treating Physician Rule.

The United States argues that the presumption of validity accorded the views of treating physicians under the Social Security Act does not justify use of any similar presumption when courts review ERISA benefit decisions, particularly in view of the Department of Labor's ("DOL") failure to adopt such a presumption in recently promulgated regulations. Contrary to the United States' suggestion, however, the origins of the presumption used in the Social Security context in no way undermine the rationale behind that presumption. Nor do the DOL regulations preclude recognition of the treating physician rule.

The United States notes that the treating physician rule used in the Social Security context originated with several circuit courts, not with the agency itself, and was ultimately adopted to bring uniformity to adjudications under a nationwide program. U.S. Br. at 19-21. The regulation itself, however, expressly states that the treating physician rule is predicated on the fact that treating physicians "are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations." 20 C.F.R. § 404.1527(d)(2). The Commissioner reiterated this rationale, moreover, in the commentary explaining the rule's adoption.[6] Whatever the historical origins of the rule, therefore, they do not alter the rule's central rationale, which is that treating physicians are likely to have a unique perspective on a patient's condition and medical needs.[7] That

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[6] *See* 56 Fed. Reg. 36,932, 36,935 (Aug. 1, 1991) (recognizing that "medical opinions—especially those from treating sources – can provide evidence of the nature and severity of an individual's impairment[s] that cannot be obtained by any other means") (alteration in original); *id.* ("We give treating source medical opinions special deference because treating sources usually have the most knowledge about their patients' conditions"); *id.* at 36,936 (rules on weighing treating source opinions that are not entitled to controlling weight were still written "in recognition of the special kind of knowledge about the nature and severity of their patient's impairments that only treating sources can have").

[7] The Department of Labor has similarly explained its version of the treating physician rule in the context of black lung benefits: "special weight may be given a treating physician's opinion because that physician has been able to observe the miner over a period of time, and therefore may have a better understanding of the miner's physical condition." 64 Fed. Reg. 54,966, 54,976 (Oct. 8, 1999). *See also* 65 Fed. Reg. 79,920, 79,931 (Dec. 20, 2000) ("The Department [of Labor] emphasized the real purpose of the rule: to recognize that a physician's professional

same rationale, of course, justifies use of a treating physician rule under ERISA.

Contrary to the government's claim, moreover, the DOL's recently promulgated regulations do not preclude recognition of such a rule. These regulations specify that a plan's procedures for reviewing claims must "[p]rovide for a review that takes into account all comments, documents, records, and other information submitted by the claimant." 29 C.F.R. § 2560.503-1(h)(2)(iv) (2001). In addition, plans providing disability benefits must include either an "explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances," or a statement that such an explanation is available upon request. *Id.* § 2560.503-1(j)(5)(ii), (g)(1)(v)(B) (2001); *compare* 29 C.F.R. § 2560.503-1(f)(1) (1998) (specific reasons for initial denial), *and id.* § 2560.503-1(h)(3) (1998) (specific reasons for the denial on review). The treating physician rule is entirely consistent with these requirements. By requiring that the "explanation of the scientific or clinical" basis for a benefit denial expressly address the treating physician's views, the proposed rule ensures that a conflicted administrator does adequately "tak[e] into account all comments, documents, records, and other information submitted by the claimant." *Id.* § 2560.503-1(j)(5)(ii), (h)(2)(iv) (2001). Absent such a rule, it is far too easy for conflicted ERISA administrators to pay lip service to the DOL regulations without honoring their spirit.

Nor will adoption of a rule that requires substantial reasons for departing from the judgment of the treating physician require any additional new procedures. Instead, the rule relies on procedures that DOL itself has prescribed. It simply specifies the content of the "scientific or clinical" explanation that a conflicted administrator must provide when denying a claim. As the government itself recognizes, where a plan

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relationship with the miner may enhance his or her insight into the miner's pulmonary condition.") (citing 64 Fed. Reg. at 54,976).

administrator "both funds the plan and renders decisions on claims for benefits under it," there is a "special justification for expecting the administrator to explain his consideration of the material evidence submitted by the claimant." U.S. Br. at 17. The treating physician rule serves precisely this interest, using the procedures the government has established.

Finally, for these same reasons, the proposed treating physician rule will not restrict the flexibility "for . . . operating claims processing systems consistent with the prudent administration of a plan," U.S. Dep't of Labor, *Benefits Claims Procedure Regulation*, Question B-4, *at* http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html (last visited Mar. 21, 2003) or discourage employers from offering plans by "increasing plan administration, medical expenses and legal costs." Petitioner's Br. at 16. DOL regulations already require an explanation of the denial that includes the administrator's scientific or clinical judgment. Accordingly, a requirement that this explanation address the treating physician's opinion and provide an explanation for why the conflicted administrator has rejected that opinion entails virtually no additional burdens or costs, and does not limit claims processing flexibility. Thus, for example, if such an administrator rejects a treating physician's opinion because it is not accompanied or supported by clinical findings, or because laboratory results not considered by the treating physician undermine the diagnosis, it is a simple matter for the administrator to specify these reasons in the required explanation. Indeed, because a failure to do so cannot be justified by considerations of cost or administrative burden, courts can properly conclude that the failure results from the improper influence of the conflict on the administrator's decision.

D. The Conflicted Plan Administrator Failed To Provide An Adequate Explanation For Refusing To Accept The Views Of Respondent's Treating Physicians.

In this case, because the conflicted plan administrator failed to provide an adequate explanation for rejecting the views of respondent's treating physicians, the lower court properly concluded that the administrator had abused its discretion in denying respondent's benefit claim. As noted above, respondent was examined and treated by a number of physicians practicing in a number of specialties. All of them – including Dr. Mitri, the neurologist selected by MetLife (the plan's designated agent) – agreed that respondent was suffering from degenerative disc disease. Respondent's treating physicians, one of whom examined respondent repeatedly following the onset of his back condition, concluded that respondent could not sit for more than one hour each day.

When the administrator initially rejected Nord's claim, it made no mention of the treating physician's diagnosis of degenerative disc disease. The administrator simply stated that a single office note by Dr. Silva indicated that respondent could "tolerate" pain with medications, and that respondent had indicated that he could do some housework and mow his lawn. L. 144-45. In upholding the benefits denial after appeal, Black & Decker on MetLife's recommendation acknowledged that its own examiner agreed with the treating physicians that respondent suffers from degenerative disc disease, as well as chronic myofascial pain syndrome. Black & Decker nevertheless concluded that respondent was not disabled. L. 156.

None of the reasons Black & Decker recited provides a basis for rejecting the treating physicians' conclusion that respondent could not sit for more than an hour each day. Black & Decker failed to even address two of the tests that the treating physicians had used in their diagnosis. Moreover,

Dr. Mitri's statement that there was no root compression was not relevant to Nord's functioning because there are other causes of degenerative disc disease and pain. Indeed, Dr. Mitri himself was aware that respondent's tests showed no nerve root compression, and that respondent's "general and neurological examination [we]re essentially unremarkable and normal," yet he, too, diagnosed respondent as suffering from degenerative disc disease and myofascial pain syndrome. L. 45. See also John Greer, *Accommodating Individuals with Back Impairments*, U.S. Dep't of Labor, *available at* http://www.nam.wvu.edu (last visited Mar. 10, 2003) (noting that "nerve impingement" is only one of several possible causes of back pain); *Harrison's Principles*, *supra*, at 82 (discussing causes of lumbar disc disease).

The administrator's final decision in fact offers no explanation at all for rejecting the treating physicians' conclusions. And while petitioner faults the treating physicians for failing to review respondent's job description, Petitioner's Br. at 6-7, it is undisputed that his job required respondent to sit for five to six hours a day and required him to lift up to twenty pounds. Pet. App. 20; L. 143. In light of the plan administrator's conflict of interest, this complete failure to explain the basis for rejecting the views of the treating physicians constitutes an abuse of discretion.

Nor is there any reason to remand this case for further consideration of the evidence that petitioner now cites in support of the denial. Given the consensus concerning respondent's diagnosis, the central issues bearing on his ability to perform his job are the amount of pain his condition causes and the extent to which that level of pain impairs his ability to sit. Dr. Mitri opined that respondent "should be able to do sedentary work with some interruption by walking in between," L. 45, but nowhere did he state how many hours of sedentary work he thought respondent could perform, let alone explain why he disagreed with the treating physicians'

view that respondent could not sit for more than an hour a day.

Dr. Hartman's judgment that Nord could not do more than an hour of sedentary work each day was based on no fewer than twelve examinations between July 1997 and March 1998. L. 54-59. Dr. Hartman was fully aware of the medications respondent was taking and their effectiveness. His judgment that respondent could not sit for more than an hour a day was a fully informed one based on sophisticated diagnostic tests and repeated examinations and consultations. See Love, *supra*, at 1003 (treating physicians "develop an accumulated knowledge about their patient's medical conditions" that "goes beyond simply knowing the patient's diagnosis and medications" and "includes a finer understanding of the severity of each medical problem"). That judgment simply was not rebutted by Dr. Mitri's unexplained contrary opinion.

The unsurprising fact that "medication help[ed]" respondent, L. 89, does not cast the slightest doubt on Dr. Hartman's assessment of respondent's ability to do sedentary work. Nor is that assessment undermined by Dr. Silva's unexplained notation that respondent feels "worst [without] medication but is tolerated [with] medications." L. 87. Medically speaking, "tolerating" pain is not synonymous with "functioning normally"; a patient can "tolerate" pain with medication, yet still be unable to sit for more than an hour a day. Finally, the fact that respondent was able to do some housework (with the assistance of his parents) and mow a lawn of unspecified size and gradation in no way establishes that he can sit for more than an hour a day. Black & Decker further appears to have abandoned these reasons by failing to identify them in the final denial of the benefits claim.

In short, the plan administrator failed to provide a substantial explanation for why it was rejecting the views of the patient's treating physician. Nor has it offered any such explanation in its submissions to the lower court or to this

Court. Because the plan was operating under a conflict of interest, this failure should be deemed an abuse of discretion.

CONCLUSION

For the foregoing reasons, the AMA urges the Court to affirm the judgment of the Ninth Circuit in this case.

Respectfully submitted,

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